



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

# HCFA Financial Report



FISCAL YEAR 2000

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# OUR MISSION, VISION, AND GOALS

## Mission

*We assure health care security for beneficiaries.*

Health care security means access to affordable and quality health care services, protection of the rights and dignity of beneficiaries, and provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

## Vision

*In the stewardship of our programs, we lead the Nation's health care system toward improved health for all.*

This vision reflects our commitment that all individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income or other circumstances, and the quality of health care they receive is the best that can be provided.

## Goals

- Protect and improve beneficiary health and satisfaction.
  - Promote fiscal integrity of HCFA's programs.
  - Purchase the best value health care for beneficiaries.
- Promote beneficiary and public understanding of HCFA and its programs.
- Foster excellence in the design and administration of HCFA's programs.
- Provide leadership in the broader public interest to improve health.



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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**



## ***A Message from the Acting Deputy Administrator***



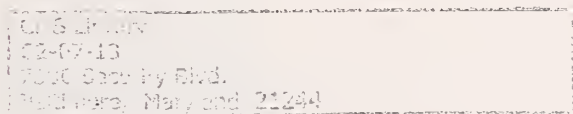
I am pleased to provide the Health Care Financing Administration's (HCFA's) annual financial report for fiscal year (FY) 2000. HCFA is the nation's largest health insurer, providing coverage to nearly 69 million beneficiaries. Our programs – Medicare, Medicaid, and the State Children's Health Insurance Program – accounted for \$316 billion in FY 2000 outlays and represent the Federal Government's third largest outlay. The Medicare Program which celebrated its 35th anniversary in 2000, processes almost 890 million fee-for-service claims a year, is the nation's largest purchaser of managed care, and accounts for 11 percent of the Federal budget.

During FY 2000, we continued our effort to provide accurate and easy to use information about Medicare. The HCFA's consumer information Web site, [www.medicare.gov](http://www.medicare.gov), won first place, the Gold Award, for Best Health Site in the annual eHealthcare World Awards. We are very proud of our Web sites, our telephone hot line, 1-800-MEDICARE, and our "Medicare & You" handbook, which was mailed to 34 million homes this year and won a government award for excellence. All are part of our comprehensive effort to provide people with Medicare the most up-to-date program information, so that they can make informed health care choices.

We have taken great strides in our efforts to ensure the fiscal integrity of our programs. Working with our partners in the provider and beneficiary community, we have initiated educational efforts and other corrective actions over the past two years designed to increase billing compliance and decrease payment errors. In addition, we have worked with our law enforcement partners to aggressively root out those instances of true fraud that rob the program and its beneficiaries of needed resources. Since HCFA's first comprehensive audit, Medicare has cut its payment error rate in half from 14 percent to 6.8 percent in FY 2000. HCFA has taken steps to recover all inappropriate payments identified by the Office of Inspector General and has recovered more than 90 percent of the overpayments identified in previous audits.

As an agency with stewardship for more than \$300 billion, HCFA takes its financial management responsibilities very seriously. Working closely with our auditors, we have a more accurate picture of our programs' financial status and clearer understanding of the financial management improvements we need to implement. As an indication of the significant progress we have made so far, I am pleased to report that our auditors have once again issued us a clean opinion on our FY 2000 Financial Statements.

I am proud of what we have accomplished and the steps we have taken to ensure that financial management receives proper focus and emphasis within HCFA. We continue to successfully work with Congress, the States, our beneficiaries, and the health care community to ensure that our programs are strong and well managed. I am confident we will continue meeting these challenges.



Michael McMullan  
February 2001

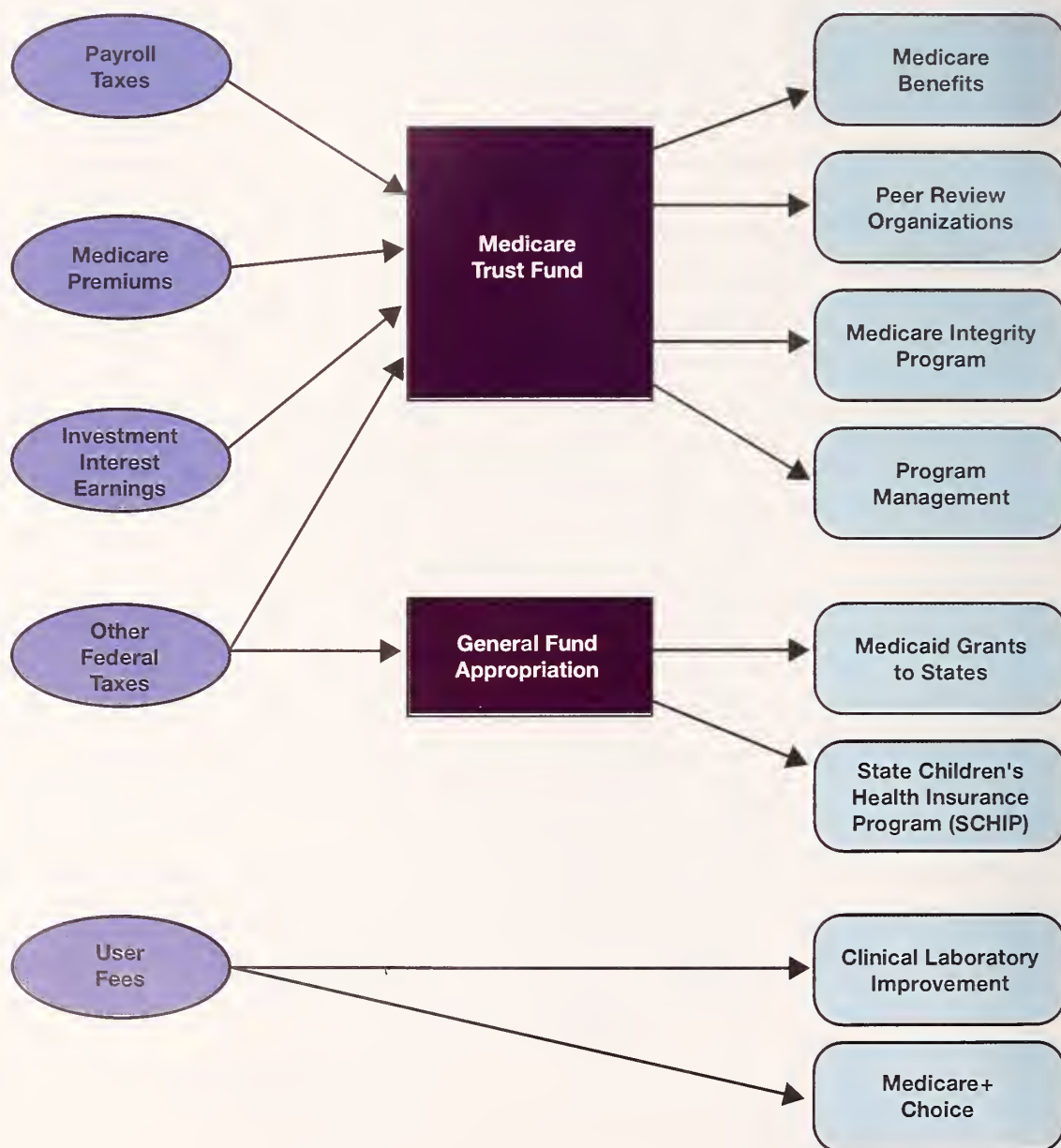


# FINANCING OF HCFA PROGRAMS AND OPERATIONS

Funds Flow From ...

... Through ...

... To Finance ...







## ***A Message from the Chief Financial Officer***



**A**s the Chief Financial Officer (CFO), I am pleased to present the HCFA Financial Report for FY 2000. As an Agency with one of the largest budgets in the Federal government, with outlays totaling over \$300 billion a year, HCFA has the responsibility to safeguard the assets of the Medicare, Medicaid, and State Children's Health Insurance programs and ensure that these programs are well managed. Through partnerships with the Department of Health and Human Services, the Office of Inspector General (OIG), State agencies, and our Medicare contractors we have made significant progress in improving HCFA's financial management operations.

An important barometer of our ability to effectively manage our programs is our ability to produce reliable, timely, and accurate financial statements that can be used for decision-making. Therefore, I am pleased to report that our auditors have found that our financial statements fairly present, in all material respects, HCFA's financial position. FY 2000 marks the second consecutive year HCFA's financial statements have received an unqualified opinion.

While this is an important achievement, we recognize that additional efforts are needed if we are to meet our responsibilities to establish a strong and effective financial organization at HCFA. This year, we addressed the majority of OIG's list of HCFA's Management and Performance Challenges. Furthermore, we developed a Chief Financial Officer (CFO) Comprehensive Plan for Financial Management to provide a coordinated approach to address our financial management goals. The CFO Comprehensive Plan highlights 10 key goals that are supported by 25 initiatives critical to HCFA's ability for sustaining a clean audit opinion and improving financial management. The four key financial management objectives of the plan are to:

- Improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable HCFA managers and other decision makers to make timely and accurate program and administrative decisions.
- Design and implement effective financial management systems that comply with the Federal Financial Management Improvement Act.
- Improve debt collection and internal accounting operations.
- Validate key financial data to ensure its accuracy and reliability.

The plan will serve as our road map to improve financial management at HCFA, improve financial stewardship of the Medicare trust funds, and provides a clear statement against which progress can be measured.

I am also pleased to report that we are making substantive progress in the successful implementation of the Debt Collection Improvement Act. In FY 2000, HCFA referred \$2 billion in delinquent debt for collection to the Department of the Treasury. In addition, we have strengthened oversight of our Medicare contractors by enhancing the effectiveness and quality of our Contractor Performance Evaluation reviews and conducting internal control and accounts receivable reviews at our largest Medicare contractors. To emphasize the importance of financial accountability, we have also required each Medicare contractor to establish a CFO position responsible for Medicare financial

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management activities and focus their attention on needed improvements. We believe these changes will substantially strengthen our contractor oversight activities.

In FY 2000, we continued to further define and implement our overall strategy for reducing payment errors in the Medicare and Medicaid programs. Our program integrity strategy focuses on four key payment safeguard principles: Prevention, Detection, Enforcement, and Coordination. Our primary goal is to reduce the CFO audit Medicare fee-for-service payment error rate to 5 percent by 2002. Our effective Program Integrity Efforts continue to reduce the error rate. The rate currently stands at 6.8 percent, and meets the FY 2000 Government Performance and Results Act goal of 7 percent. We are continuing to develop methods to help us focus our efforts and resources to reduce the error rate further and increase efficiency, effectiveness, and consistency in the application of Medicare coverage and payment rules.

One of HCFA's most daunting financial management challenges continues to be the lack of a financial management system that fully integrates HCFA's accounting systems with those of our Medicare contractors. As a result, our auditors continue to have internal control concerns with many aspects of our Medicare contractors' financial management operations – especially accounts receivable. Therefore, a major component of our CFO Comprehensive Plan is to purchase a state-of-the-art, integrated accounting system, which will include our Medicare contractor activities. This project is the HCFA Integrated General Ledger Accounting System (HIGLAS). HIGLAS represents a major information technology investment to standardize the collection, recording, and reporting of Medicare financial information in order to enhance the management, accounting, and oversight of our programs. This project is well underway. On January 31, 2001, we issued a request for quotation and demonstration that will result in the procurement and implementation of a commercial-off-the-shelf accounting system, the selection of which will require approval by the Departments' Information Technology Acquisition Review Board. We will continue to perform detailed reviews of Medicare contractors' financial data and internal controls to ensure proper accountability and management.

While the achievement of an unqualified audit opinion is a key accomplishment, we know we have more work to do in improving HCFA's financial management. Ensuring the financial integrity and efficiency of our programs is essential to meeting our responsibilities to our nation's taxpayers and to our Medicare and Medicaid beneficiaries. I am proud of the accomplishments we have achieved thus far, and I am confident we will continue to build on this success in the future.



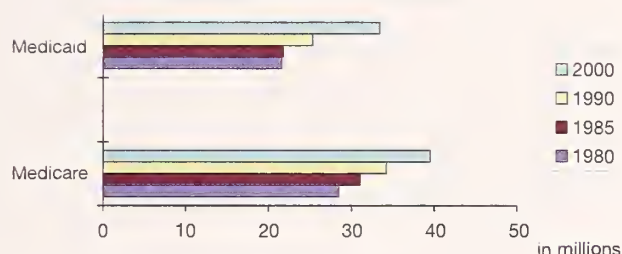
A. Michelle Snyder  
February 2001



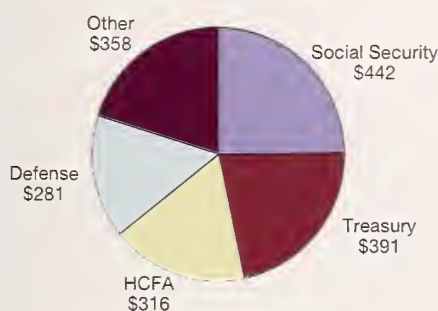
# THE HEALTH CARE FINANCING ADMINISTRATION AT A GLANCE

**HCFA** is the largest purchaser of health care in the world. The Medicare and Medicaid programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19.5 million beneficiaries in 1967 to 39.5 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to 33.4 million beneficiaries.

2000 Program Enrollment



2000 Federal Outlays



Source: U.S. Treasury

in billions

**HCFA** outlayed \$316.2 billion (net of offsetting receipts) in fiscal year (FY) 2000, 17.7 percent of total Federal outlays. The only agencies that outlayed more are the Social Security Administration and the Department of Treasury.

**HCFA** has 4,600 Federal employees, but does most of its work through third parties. HCFA and its contractors pay more than 890 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. HCFA also assures the safety and quality of medical facilities, provides health insurance protections to workers changing jobs, and maintains the largest collection of health care data in the United States.

## HCFA and Its Partners

	Employees
HCFA	4,600
State Medicaid/SCHIP	34,000
Medicare Contractors	21,700
State Surveyors	6,000
Peer Review	2,600

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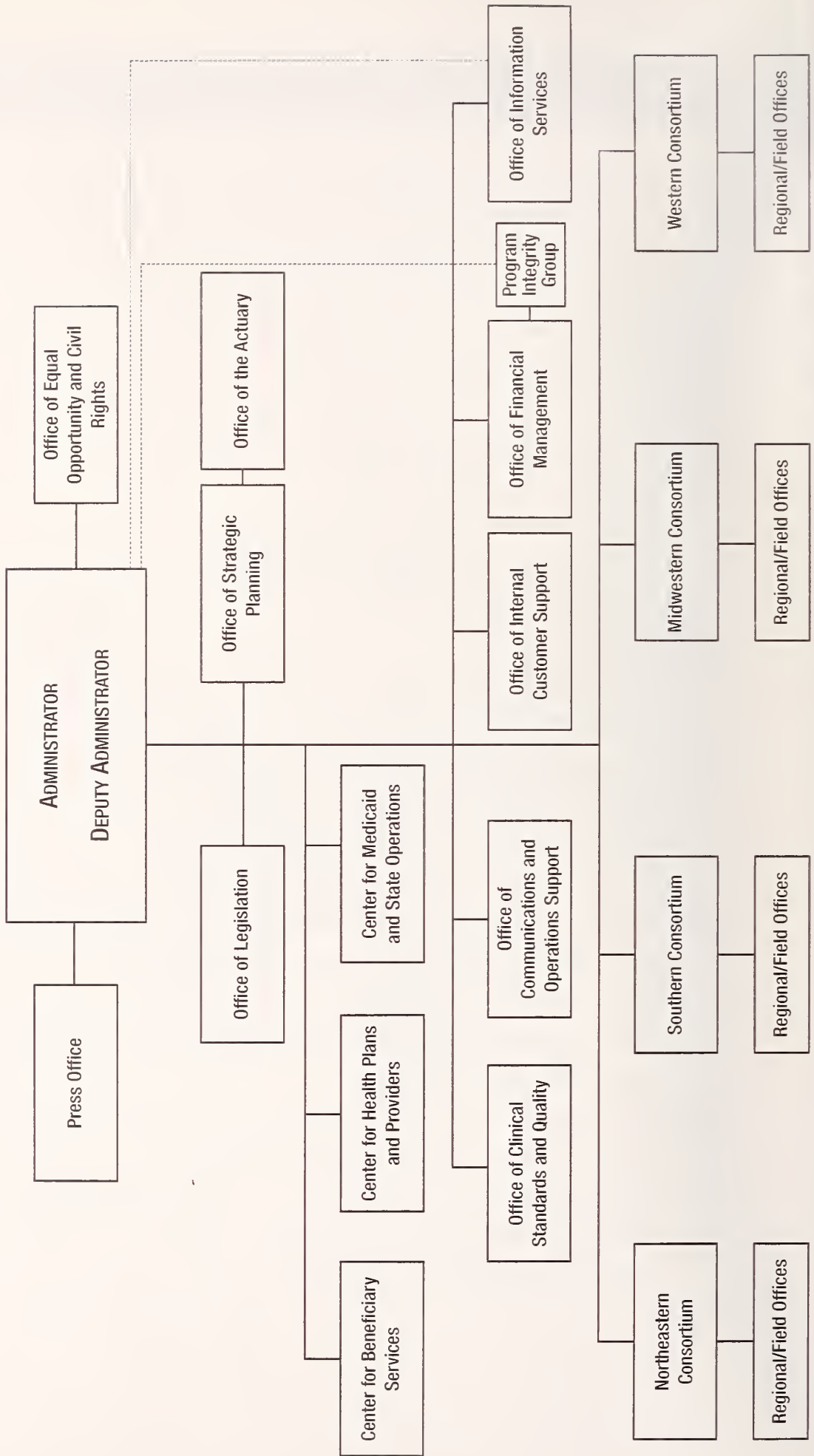


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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

## HEALTH CARE FINANCING ADMINISTRATION





**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**

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# **Management's Discussion and Analysis**

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**HCF**



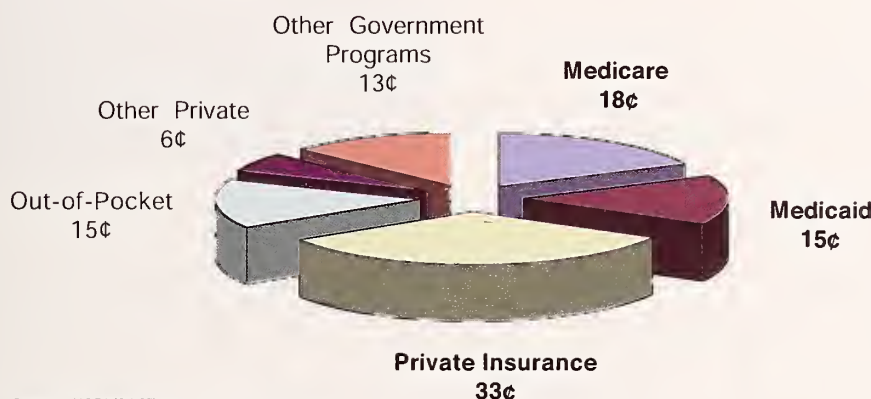


## **OVERVIEW**

The Health Care Financing Administration (HCFA), an operating division of the Department of Health and Human Services (HHS), is responsible for administering Medicare, Medicaid, the State Children's Health Insurance Program, and the Clinical Laboratory Improvement Act. In conjunction with the Departments of Labor and Treasury, HCFA is also responsible for oversight of the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays, including State funding, represent 33 cents of every dollar spent on health care in the United States – 58 cents of every dollar spent on nursing homes, 48 cents of every dollar received by U.S. hospitals, and 27 cents of every dollar spent on physician services.

### **The Nation's Health Care Dollar 1999**



Source: HCFA/OACT

Note: 1999 is most current data available

HCFA outlays totaled \$316.2 billion (net of offsetting receipts) in fiscal year (FY) 2000, or 17.7 percent of total Federal outlays. HCFA establishes rules for program eligibility and benefit coverages; processes more than 890 million claims annually; provides States with funds for the Medicaid and the State Children's Health Insurance Programs; assures quality of health care for beneficiaries; safeguards funds from fraud, waste, and abuse; and carries out many other important activities.

Of HCFA's 4,600 Federal employees, about 1,600 work in 10 regional offices around the country providing direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. Approximately 3,000 of HCFA's employees work in Baltimore and Washington, D.C., providing funds to Medicare contractors; writing policies and regulations; developing more efficient operating systems; setting payment rates; safeguarding the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for appropriate, medically necessary services are paid correctly the

first time; recovering improper payments; and assisting law enforcement agencies in the prosecution of fraudulent activities, monitoring contractor performance; developing and implementing customer service improvements; providing education and outreach activities to beneficiaries; surveying hospitals, nursing homes, labs, home health agencies and other health care facilities; working with State insurance companies; and assisting States and Territories with Medicaid and the State Children's Health Insurance Program. In addition, HCFA is responsible for maintaining the Nation's largest collection of health care data and providing data and technical assistance to the Congress, the Executive Branch, universities, and other private sector researchers.

In FY 2000, HCFA's expenses totaled \$339.1 billion. HCFA's administrative expenses totaled \$2.2 billion, which is less than one percent of total expenses. In addition to HCFA's 4,600 employees, many important operational activities are handled by third parties: (1) 34,000 state employees have responsibility for administering the Medicaid and State Children's Health Insurance Program (2) 21,700 employees at 54 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and servicing beneficiaries needs, including enrollment and premium billing, and responding to inquiries; (3) 6,000 State employees have primary responsibility for inspecting hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) 2,600 employees at 53 Peer Review Organizations conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

**Two key financial terms** are critical to understanding the HCFA financial story. **Expenses** are one of the ingredients of the financial statements that begin on page 47. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. Wherever possible, expenses are the basis for discussions of HCFA's financial activity. **Outlays** refer to the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. Outlays are used in the discussions of HCFA's financial activity only when comparable expense data are not available.

## HCFA'S PROGRAMS

### Medicare

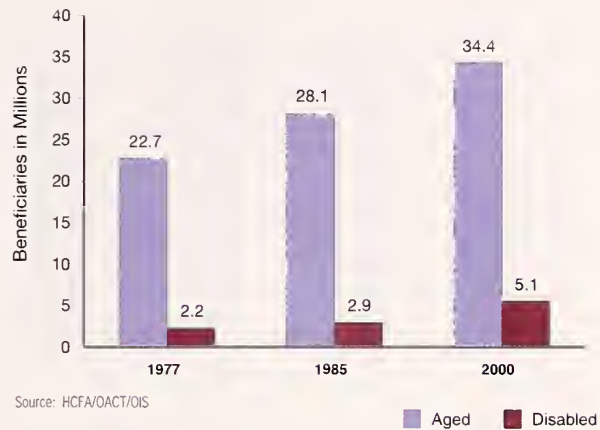
#### *Introduction*

Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. In 1972, the program was broadened to cover the disabled, people with end-stage renal disease

(ESRD) requiring dialysis or kidney transplant, and certain others who elect to purchase Medicare coverage.

Medicare is a combination of two programs, each with its own enrollment, coverage, and financing — Hospital Insurance and Supplementary Medical Insurance. The Balanced Budget Act of 1997 (BBA) created a third program called Medicare+Choice that provides a choice of health insurance options and provides funding for better consumer information. Since 1967, Medicare enrollment has increased from 19.5 million to 39.5 million beneficiaries.

**Medicare Enrollment**



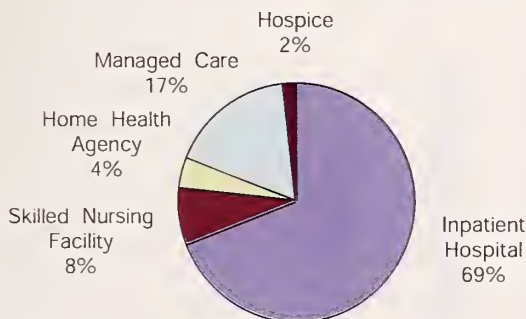
## Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays for hospital, skilled nursing facility, home health, and hospice care.

The HI program is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Inpatient hospital spending accounted for 69 percent of HI benefits outlays. Managed care spending comprised 17 percent of total HI spending. During FY 2000, HI benefits outlays fell by 2.4 percent. HI benefit outlays per enrollee dropped 3.4 percent to \$3,220.

**HI Medicare Benefit Payments**



## Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over and disabled people entitled to Part A. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by HI. The SMI coverage is optional and beneficiaries are

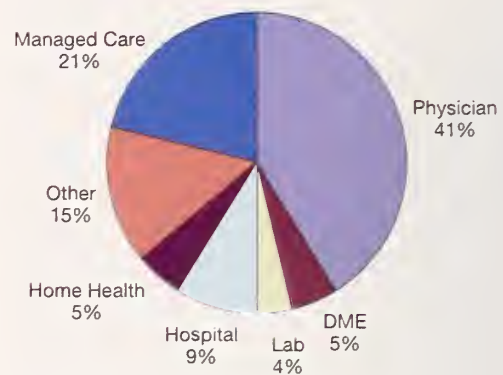


subject to monthly premium payments. About 95 percent of HI enrollees elect to enroll in SMI.

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Income not currently needed to pay benefits and related expenses is held in the SMI trust fund, and invested in U.S. Treasury securities.

During FY 2000, SMI benefit outlays grew by 12.3 percent. Physician services, the largest component of SMI, accounted for 41 percent of expenditures. SMI benefit outlays per enrollee increased 11.3 percent to \$2,380.

**SMI Medicare Benefit Payments**



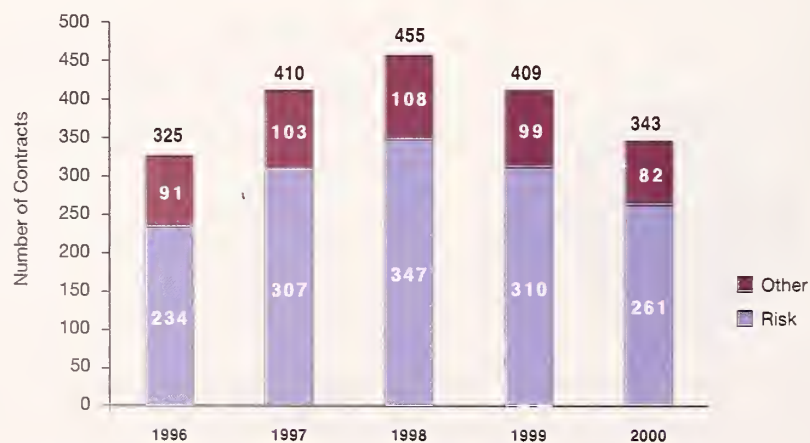
Source: HCFA/OACT

## Medicare+Choice

The BBA created a third Medicare program, Medicare+Choice, sometimes referred to as Medicare Part C. With the exception of those with end stage renal disease, any Medicare beneficiary may join a Medicare+Choice plan if one is available in his or her area.

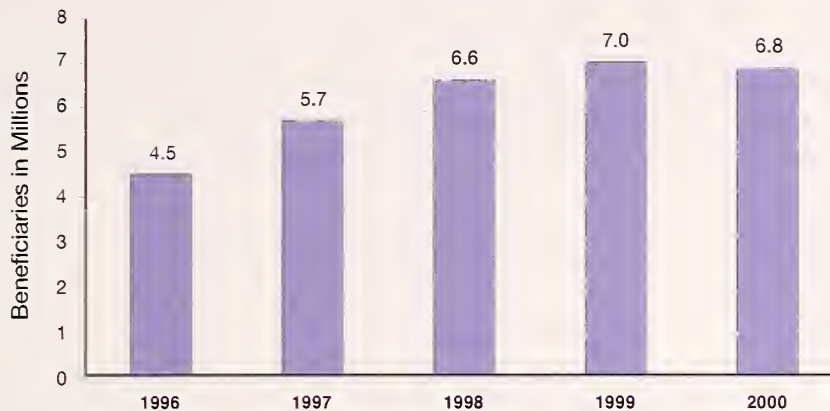
BBA's goal is to make Medicare attractive for new entities to provide health insurance choices to beneficiaries. In creating the Medicare+Choice program, the BBA restructured the capitation rates for Medicare managed care and provided user fees to fund a consumer information campaign, which would provide beneficiaries with comparative plan information. Although there has been recent concerns over plans leaving the Medicare program, the number of managed care plans increased from 193 in FY 1993 to 343 contracts (coordinated care plans, cost-based contracts, demonstrations,

**Medicare Managed Care Contracts**



Source: HCFA/CHPP

### Managed Care Enrollment



Source: HCFA/CHPP

and Health Care Prepayment Plans) in FY 2000. Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional fee-for-service (FFS) arrangements.

In general, managed care organizations have their own providers or a network of contracting health care providers that agree to provide health care services for health maintenance organizations (HMO) or prepaid health organization's members. Managed care organizations currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, private fee-for-service plans, cost, and health care prepayment plans (HCPP), as well as certain demonstration projects.

Coordinated Care Plans, private fee-for-service plans, or Medicare+Choice plans are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide, at a minimum, all Medicare covered services. Most Medicare+Choice plans offer additional services such as prescription drugs and eyeglasses to beneficiaries. Cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, but do not always provide the additional services that some risk Medicare+Choice plans offer. HCPPs are paid in a manner similar to cost contractors, but generally cover only Part B Medicare services. Section 1876 cost-based contractors and HCPPs, with certain limited exceptions, phase out under the BBA provisions.

Since 1996, Medicare beneficiaries enrollment in managed care plans has increased from 4.5 million to a total of 6.8 million in 2000, which represents 17 percent of the total Medicare population. Managed care expenses accounted for \$39.8 billion of the total \$ 214.7 billion in Medicare benefit payment expenses in FY 2000.

In FY 2001, about 85 percent of current Medicare+Choice beneficiaries will be able to continue with their current Medicare HMO. Sixty-five Medicare+Choice HMOs chose

not to renew their Medicare+Choice contracts and 53 reduced their service areas, affecting more than 934,000 Medicare beneficiaries. About 775,000 of the affected beneficiaries, will be able to enroll in another Medicare HMO, if the HMO is accepting enrollees. About 17 percent or 159,000 of the remaining beneficiaries will be left with no Medicare+Choice HMO options, although some may choose to enroll in a private fee-for-service plan if one is available in their community. All beneficiaries who are affected by these nonrenewals may return to original fee-for-service Medicare.

## **Medicaid**

### ***Introduction***

Medicaid is the means-tested health care program for low-income Americans, administered by HCFA in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was 33 million in 2000, about 12 percent of the U.S. population. Approximately 6 million people are dually entitled, that is, covered by both Medicare and Medicaid.

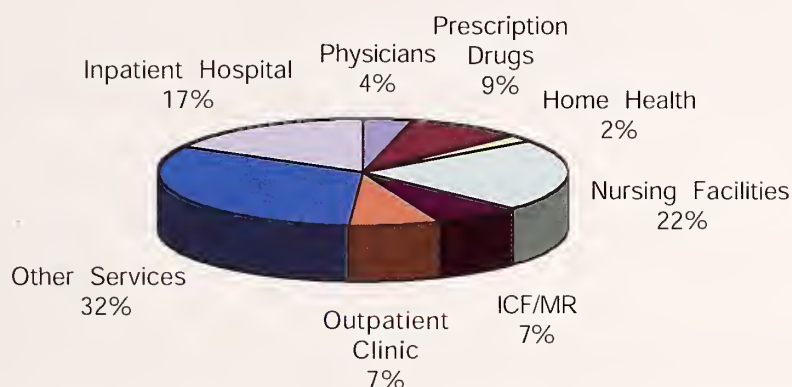
HCFA provides matching payment grants to States and Territories to cover Medicaid program and administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 2000, the Federal matching rate for Medicaid program costs among the States ranged from 50 to 77 percent, with a national average of 57 percent. Federal matching rates for various State and local administrative costs are set by statute, and in FY 2000 averaged 56 percent. Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States, except with respect to the disproportionate share program and payments to territories.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled and elderly population), low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning, nursing facility services, and health screening for children under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States.



Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2000 is estimated to be about \$4.1 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

## Medicaid Vendor Payments



Source: HCFA/OIS

## Payments

Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. In FY 2000, State and Federal ADM outlays were \$10.8 billion – only 5 percent of the total Medicaid outlays. State and Federal MA outlays were \$196.3 billion or 95 percent of total Medicaid outlays, an increase of nearly 9 percent over FY 1999. HCFA's share of Medicaid expenses totaled \$118.6 billion.

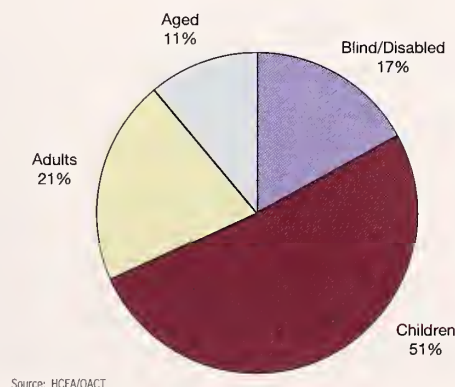
## Enrollees

An estimated 33.4 million persons were enrolled in Medicaid in 2000. Children comprise 51 percent of Medicaid enrollees, but account for only 16 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 28 percent of Medicaid enrollees, but accounted for 67 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

## Service Delivery Options

Many States are pursuing managed care as an alternative to the FFS system for their Medicaid

## Medicaid Enrollees



Source: HCFA/OACT

programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by HCFA to introduce managed care plans tailored to their State and local needs, and there are currently 48 States offering a form of managed care. The number of Medicaid beneficiaries enrolled in managed care had grown from slightly under 15 percent in 1993 to an estimated 56 percent by 2000.

HCFA and the States have worked in partnership to offer managed care to Medicaid beneficiaries. States may elect to include the Program of All-Inclusive Care for the Elderly (PACE) as a State plan option. PACE is a prepaid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who are eligible for nursing home care according to State standards. Medicaid law also provides for two kinds of waivers of existing Federal statutes to allow for the implementation of managed care.

- 1) State health reform waivers – Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects, and
- 2) Freedom of choice waivers – Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

### **State Children's Health Insurance**

The State Children's Health Insurance Program (SCHIP) was created through the Balanced Budget Act to address the fact that nearly 11 million American children – one in seven – are uninsured and therefore at significantly increased risk for preventable health problems. Many of these children are in working families that earn too little to afford private insurance on their own but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside \$24 billion over five years, beginning in FY 1998, to create SCHIP – the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is

actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, or a combination of these approaches.

States also have the opportunity to set eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

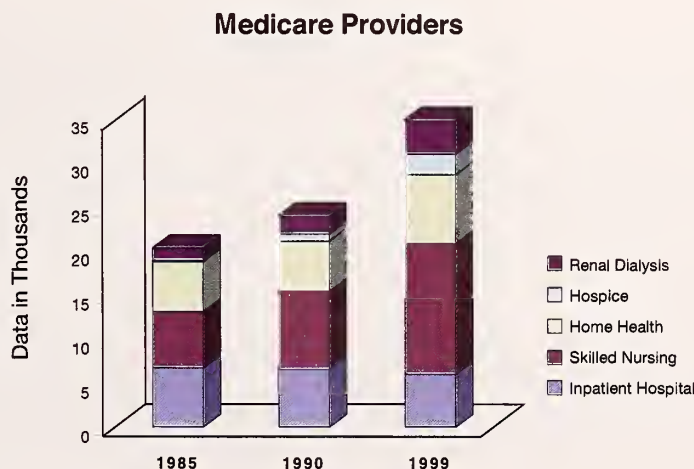
HCFA works closely with States, Congress, the Health Resources and Services Administration and other Federal agencies to meet the challenge of implementing this program and defining its parameters, while at the same time, approving State plans as quickly as possible. HCFA provides extensive guidance and interim instructions so States can develop their plans and start using Federal funds to begin insuring children at the earliest possible date. As of September 30, 2000, all 50 States, the District of Columbia, and the commonwealths and territories had approved child health plans. Of these, 23 are Medicaid expansions, 15 are separate State Child Health plans, and 18 are combination plans. In addition, 57 amendments have been approved.

## Other Activities

In addition to making health care payments on behalf of our beneficiaries, HCFA makes other important contributions to the delivery of health care in the United States.

### *Survey and Certification Program*

HCFA is responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the



Source: HCFA/OIS



Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments.

### ***Clinical Laboratory Improvement Program***

The Clinical Laboratory Improvement Amendments of 1988 (CLIA), expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens from the human body. HCFA regulates all laboratory testing (whether provided to beneficiaries of HCFA programs or to others) including those in physicians' offices. HCFA, in partnership with the States, certify and inspect approximately 14,500 laboratories each year. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly operated by three of the Health and Human Services agencies: 1) HCFA provides financial management of the program, contracts with surveyors to inspect labs, and offers general administrative support, 2) The Center of Disease Control (CDC) provides research support; and 3) The Food and Drug Administration, (FDA) who oversees test categorization.

There has been an overwhelming growth in providers with the largest increases in skilled nursing facilities, home health agencies, hospices, and end-stage renal dialysis facilities. Certified Medicare providers have increased from about 22,000 in FY 1985 to nearly 40,000 today. This total does not include the 170,000 clinical laboratories.

### ***Quality of Care***

Through Peer Review Organizations, ESRD Networks, State agencies, and others, HCFA collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

In addition, our provider conditions of participation or coverage are moving towards outcome based measures. We continue to believe that providers must ensure that there is an effective quality-assurance program to evaluate the provisions of patient care. As a result, all of our provider conditions of participation or coverage are being updated to assure that providers have a demonstrated organizational commitment to provide and improve upon the quality of care to our beneficiaries. These entities should measure, analyze, and track quality indicators, including adverse patient events or other aspects of performance that reflect processes of care and program operations.

### ***Coverage Policy***

In today's health care market, every insurer and health care purchaser must deal with coverage policy. We established a new process that will facilitate input from all stakeholders, including beneficiaries, through the Medicare Coverage Advisory Committee (MCAC). The MCAC holds open meetings and includes consumer, as well as industry

members. We also rely on state-of-the-art technology assessment and support from other Federal agencies, as well as considerable staff expertise.

Medicare is a leader in evidence-based decision making for coverage policy. Our own extensive payment data contain additional useful information that is used by the Agency for Healthcare Research and Quality (AHRQ) and others for assessing the effectiveness of a variety of medical treatments.

### ***Insurance Oversight***

HCFA has primary responsibility for setting standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. HCFA works with State insurance commissioners' offices to ensure that suspected violations of the laws governing the marketing and sales of Medigap are addressed.

HCFA is also responsible for implementing the data standards provision of HIPAA. The administrative simplification provision is aimed at reducing administrative costs and burdens in the health care industry. It requires HHS to adopt national uniform standards for the electronic transmission of certain health information. HCFA is working with both public and private organizations to develop the best standards possible with strong safeguards to ensure privacy of records. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic transmission of specified transactions.

As a result of the insurance reform provisions of HIPAA, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. HCFA works with the State Insurance Commissioners offices, the U.S. Department of Labor and the Internal Revenue Service to implement these provisions. The common goal is to improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market. These new consumer protections affect an estimated 160 million individuals.

## **PERFORMANCE GOALS**

The Government Performance and Results Act (GPRA) of 1993 requires Federal agencies to prepare 5-year strategic plans setting out long-term goals and objectives, Annual Performance Plans (APP) committing to short-term performance goals, and Annual Performance Reports (APR) explaining and documenting how effective the Agency's actions have been at achieving the stated goals.

HCFA's performance measurement approach is based on two principles: (1) the most important things to measure relate to ensuring that HCFA's beneficiaries receive

the high quality care they need; and (2) the measures will be **representative** of program performance.

The APP describes HCFA's performance goals, their linkage to longer-term strategic goals and to the budget, as well as the steps planned and underway to accomplish each goal. The plan also establishes a method and data source for measuring and reporting on each goal. The FY 2000 performance plan includes 30 significant performance goals for HCFA programs designed to provide coverage of major program areas and budget categories.

All HCFA performance goals relate to important outcomes such as improved beneficiary health and satisfaction, sound fiscal management of one of the largest budgets in the Federal government, and maximum use of appropriate technology to improve service, increase productivity, and minimize cost. The plan contains performance goals relating to improved use of information technology; effective implementation of Medicare+Choice and other provisions of the Balanced Budget Act (BBA) of 1997; reduction in fraud and erroneous Medicare payments; and improvements in quality of care oversight and customer service. It reflects key Administration and Agency priorities for the next several years. HCFA's performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination, as well as sound business sense. The progress we made on each of these FY 2000 performance goals will be submitted with the President's budget request.

Consistent with GPRA principles, HCFA identified a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as steward of many billions of taxpayer dollars. The Agency is confident that performance measurement under GPRA will contribute substantially to improvement in HCFA's programmatic and administrative performance. We anticipate that performance results will provide a wealth of information about the success of HCFA's programs, activities, and initiatives. This information will be useful in making policy and management choices in both the short and long term. The following section of the report is structured around HCFA's Strategic Plan. We have aligned select key performance goals and outcomes with each strategic goal.

### Goal 1

#### **Protect and Improve Beneficiary Health and Satisfaction**

HCFA has defined "quality of care" as the "extent to which health care and health-related services result in desired outcomes and greater satisfaction with care for the populations and individuals we serve." This definition of quality of care and the mission statement serve as the Agency's foundation for developing an integrated quality program framework.

**Improve access to care for the elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance.**

This performance goal focuses on reducing financial barriers to care by increasing the number of individuals who are dually qualified for Medicare and at least some



aspects of the Medicaid program. Our emphasis in the initial years of this goal is on increasing enrollment for Medicare beneficiaries who are eligible for the Qualified Medicare Beneficiary or the Specified Low-Income Medicare Beneficiary programs.

We have met our FY 2000 goal of increasing dual eligible enrollment by 4 percent. The total dual eligible enrollment target for the end of FY 2000 is 5,479,606 beneficiaries, which is an overall increase over the 1998 baseline of 314,065 beneficiaries. The actual enrollment at the end of FY 2000 was 5,499,349, an increase of 333,808. The FY 2000 enrollment target represented an increase in enrollment of 2 percent for 1999 and 4 percent in FY 2000.

### **Improve heart attack survival rates.**

This nationwide multi-year effort focuses on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks. Our target is to increase the 1-year survival rate by decreasing the mortality rate by 1 percentage point over 5 years to 27.4 percent. Data from 1996 through 1998 shows a relatively constant 1-year mortality rate. This is attributable to several factors including the fact that our effort in this area has been phased in gradually. Also, the age distribution of the Medicare population has increased which could require risk adjustment. The final data is not expected until FY 2003.

### **Increase the percentage of Medicare beneficiaries age 65 years and older who receive an influenza (flu) vaccination.**

Influenza is a potentially life-threatening, but preventable, respiratory disease. It is estimated that about 10,000 to 40,000 persons die each year in the United States from influenza and related complications. Many common health conditions in the elderly are worsened by the flu, and an annual influenza vaccination is recommended for all persons aged 65 years and older.

According to the *National Health Interview Survey* (NHIS - 1998), 64 percent of those age 65 and older were vaccinated for the flu. We are on track to meet our FY 2000 target immunization rate of 60 percent. Final NHIS survey results for this 2000 goal are expected in the summer of 2002.

### **Increase the percentage of Medicare beneficiaries age 65 years and older receiving a mammogram.**

A mammogram is a safe, low-dose x-ray of the breast and is the most effective means of detecting breast cancer while it is still in an early, treatable stage. Since older women face a greater risk of developing breast cancer than younger women, HCFA's efforts for encouraging regular mammograms is critical to reducing breast cancer among women of Medicare age.

According to the latest NHIS survey (1998), 63.8 percent of Medicare women aged 65 and older received a biennial mammogram. We are on track to meet our FY 2000 target rate of 60 percent. Final NHIS survey results for this 2000 goal are expected in the summer of 2002.

### **Increase the percentage of Medicaid 2-year old children who are fully immunized.**

Three groups of States, staggered over 4 years, will develop State-specific baselines, methods and 3-year targets to increase childhood immunization rates for their State's Medicaid 2-year olds. In FY 2000, HCFA facilitated this process by sponsoring meetings, site visits and providing technical assistance. Of the first cohort of 16 States, 13 completed developing their measurement methods, baselines and targets on schedule. The remaining States are expected to complete this phase in FY 2001.

HCFA continues to assist the second group of States during the development phase, and recruitment and development of the third group of States is well underway.

### **Decrease the number of uninsured children by working with States to implement the State Children's Health Insurance Program and increase enrollment in Medicaid.**

The BBA of 1997 created the State Children's Health Insurance Program (SCHIP). This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. States were given the option to expand their Medicaid program, establish a separate SCHIP or a combination of both. Our goal in FY 2000 was to increase the number of children (up to age 19 for SCHIP; age 21 for Medicaid) who are enrolled in regular Medicaid or SCHIP by one million over last year's level. We surpassed that goal by enrolling an additional 1.7 million children in these programs in FY 2000.

## **Goal 2**

### **Promote Fiscal Integrity of HCFA Programs**

The passage of the Health Insurance Portability and Accountability Act (HIPAA) and the BBA has a tremendous impact on the fiscal integrity of HCFA's programs. Implementation of the provisions contained in these laws will provide continuing impetus toward sound financial management and the elimination of fraud, waste, and abuse in Medicare.

### **Improve HCFA's rating on financial statements.**

As an Agency with one of the largest budgets in the Federal government, HCFA has a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. In FY 1999, HCFA improved its financial reporting and received an unqualified audit opinion. We are pleased to report that HCFA met its target of obtaining an unqualified opinion on its FY 2000 financial statements.

### **Reduce the percentage of improper payments made under the Medicare fee-for-service program.**

The purpose of this goal is to continue to reduce the percentage of improper payments made under the Medicare fee-for-service program. One of HCFA's key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers, for covered, reasonable and necessary services provided to eligible

beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. HCFA met its FY 2000 goal of a 7 percent error rate by achieving a 6.8 percent Medicare fee-for-service error rate.

### **Increase Medicare Secondary Payer liability and no-fault dollar recoveries.**

Medicare Secondary Payer (MSP) activities ensure that payment for health care services for beneficiaries is made by the appropriate payer. The MSP activity attempts to collect timely and accurate information on the proper order of payers and to make sure that Medicare pays only for those claims where it has primary responsibility. HCFA's FY 2000 target is to increase MSP recoveries reported on the HCFA-838 Credit Balance Report by 5 percent and/or decrease the time associated with such recoveries.

### **Reduce the percentage of improper payments for Medicare home health services.**

HCFA has developed and implemented tools to fight fraud and abuse in the Medicare home health program. These tools prevent inappropriate payments by restructuring coverage and identifying problem providers. HCFA's interventions in this area are progressing as planned. We expect to meet our FY 2000 target of reducing the rate of improper payments for home health services in the study States (California, Illinois, New York and Texas) to 10 percent.

### **Improve the efficiency of the medical review of claims.**

This goal is designed to track increases in the efficiency of medical review conducted by the Medicare contractors on fee-for-service claims. The efficiency of medical review increases when the contractors review more claims per dollar spent on medical review. Thus, if funding were held constant, more efficient medical review would permit a larger number of claims to be reviewed.

The target for FY 2000 was to conduct medical review on an additional 10 percent claims given current efficiency level and funding amounts. This means that approximately 9.1 million additional claims will be reviewed, bringing total claims reviewed to about 100 million. Interim data at the end of the third quarter reported that 68 million claims had been reviewed to date.

## **Goal 3**

### **Purchase the Best Value Health Care for Beneficiaries**

HCFA is the largest purchaser of health care in the United States, and is transitioning from a payer organization to a "prudent purchaser of health care services." This transition is being made through collaboration with a number of large purchasers to explore opportunities for obtaining the best value in quality, cost-effective health care services for our beneficiaries. To that end, we have created a user-friendly system that



will enable HCFA to deal with our provider groups and advocacy communities and will enhance coordination of customer correspondence, report gathering and research.

We are developing purchasing strategies along with other large purchasers of health care, that will help us attain our goal of providing high quality health care for the best value in services for the dollars we spend for both managed care and fee-for-service.

### **Decrease the prevalence of restraints in nursing homes.**

The prevalence of the use of physical restraints is an accepted indicator of quality of care, and considered a proxy for measuring quality of life for nursing home residents. The use of restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. We expect to meet our goal of decreasing the prevalence of restraints in nursing homes to 10 percent. Interim data indicate that 9.8 percent of residents were in physical restraints in FY 2000.

### **Decrease the prevalence of pressure ulcers in long term care facilities.**

HCFA sponsors a variety of pressure ulcer reduction initiatives: a satellite broadcast education program; enhancing methods of surveyor detection of pressure ulcers using minimum data set and quality indicator reports; more detailed guidance to surveyors to detect pressure ulcer assessment and treatment deficiencies; more effective enforcement procedures to sustain compliance with Federal requirements; national educational programs in the prevention and treatment of pressure ulcers; and campaigns to raise national awareness of this significant health care problem. We met our FY 2000 goal to establish the baseline of 9.8 percent and targets for prevalence of pressure ulcers.

### **Increase health plan choices available to Medicare beneficiaries.**

This goal was designed to ensure that Medicare beneficiaries have a choice of high quality health care options in both fee-for-service and managed care plans. Expanded competition in the marketplace promotes quality, expands benefits, controls price, and stimulates innovation. We exceeded our goal of 73 percent, with 84 percent of the Medicare beneficiaries having at least one managed care choice/option in FY 2000.

## **Goal 4**

### **Promote Beneficiary and Public**

### **Understanding of HCFA and its Programs**

#### **Improve effectiveness of dissemination of Medicare information to beneficiaries.**

With clear baselines in place, we can begin to track the progress of the National Medicare Education Program toward our 5-year target for beneficiary accessibility and understanding of educational efforts regarding the Medicare+Choice program. Our goal is that by FY 2004, 77 percent of beneficiaries will report that the information they

received answered their questions and 57 percent will know that most people covered by Medicare can select from among different health plan options within Medicare.

In addition, we are aiming towards full implementation of the Medicare Summary Notice (MSN) by FY 2002. The Medicare payment contractor MSN implementation goal is at 81 percent in FY 2000.

### **Goal 5**

#### **Foster Excellence in the Design and Administration of HCFA's Programs**

##### **Enroll beneficiaries into managed care plans timely.**

It is vital that enrollments are processed timely. If the enrollment is not recorded timely, beneficiary medical coverage and managed care plan payments could be affected. Improvements in the timeliness of enrollment processing will reduce beneficiary confusion regarding the status of their medical coverage, reduce fee-for-service claims processing errors, and reduce provider frustrations regarding payment. The target of this FY 2000 goal to accurately record 98 percent of clean Medicare + Choice plan enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month) was achieved at 98.7 percent.

##### **Sustain payment timeliness consistent with statutory floor and ceiling requirements.**

During FY 2000 HCFA was able to maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims. We met this goal.

##### **Ensure millennium compliance (readiness) of HCFA computer systems.**

HCFA was extremely successful with its millennium conversion activities. We achieved our FY 2000 goal with no disruptions of Medicare and Medicaid payments or other key outputs of the Agency. All computer hardware, software, data exchanges, and telecommunications continue to be fully operational.

##### **Improve HCFA's information systems security.**

As HCFA moves further into on-line activity with increased business partners and technological complexity, the protection of confidential information becomes even more critical. HCFA is fully committed to fulfilling its stewardship responsibilities for the information contained in its data systems and transported across its networks.

In FY 1999, auditors had significant concerns regarding information systems security at HCFA central office and its Medicare contractors in the electronic data processing portion of the financial statements audit. During FY 2000, we have made significant progress in partially resolving the internal control material weakness related to HCFA central office's programming software application, M204, and deficiencies related to inappropriate access controls. We developed, tested and implemented software (SIRSAFE)

to correct the problems. However, the material weakness related to Medicare contractors' ability to modify the Fiscal Intermediary Standard System and the Common Working File still remains.

**Develop and implement an information technology architecture.**

HCFA as required by the Clinger-Cohen Act of 1996, is developing an integrated, enterprise-wide Information Technology (IT) architecture that is aligned with HCFA's strategic business objectives. The IT architecture will document the relationships between HCFA's business and management processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support HCFA's mission; and that a logically consistent set of policies and standards is developed to guide the engineering of HCFA's IT systems. HCFA's Chief Information Officer has overall responsibility for the IT architecture, and has appointed an architect to oversee its development and implementation. The FY 2000 target was to approve standards and policies for each of the 66 basic service areas identified in the HCFA IT architecture technical reference model. All basic service areas were approved and policies are being addressed as needed.

**Increase the use of electronic commerce in Medicare.**

The objective of this goal is to increase the percentage of activities accomplished electronically, rather than on paper or by the telephone. These activities consist of electronic remittance advice, electronic funds transfer, electronic claims status, electronic eligibility inquiry, and electronic media claims (EMC). Increasing the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars. Our FY 2000 target is to achieve an EMC rate of 97 percent for intermediaries and 80 percent for carriers.

**Develop new Medicare payment systems in fee-for-service and Medicare + Choice.**

This goal was designed to measure our progress towards the development of additional payment systems in fee-for-service and Medicare + Choice. We met our FY 2000 goal of implementing a prospective payment system for hospital outpatient departments and risk adjusting payments to managed care plans.

## **Goal 6**

### **Provide Leadership in the Broader Public Interest to Improve Health**

**Ensure compliance with HIPAA requirements through the use of policy form reviews.**

HIPAA was enacted to promote access to health insurance coverage to people who had lost their insurance, often through job dislocation, or who were previously uninsurable because of their health status. The Department of Health and Human Services (HHS), through HCFA, is responsible for ensuring that States enforce HIPAA provisions with respect to issuers of coverage in the group and individual markets. If States do not



have similar protections in place, do not pass appropriate laws, or do not substantially enforce them; HCFA is required to take enforcement actions.

Our FY 2000 goal is to ensure compliance with HIPAA requirements through policy form reviews in direct enforcement States. We met our FY 2000 target of reviewing 30 percent of the insurance policy forms in California, Rhode Island, and Missouri.

### **Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.**

This goal was designed to provide a complete picture of Medicare and Medicaid service utilization and expenditures. Individuals who are dually eligible for Medicare and Medicaid are an important and growing segment of beneficiaries. In FY 1995, there were approximately 6 million individuals dually eligible for Medicare and Medicaid at some point in the year. Although dually eligible beneficiaries represent about 16 percent of the Medicare population, they represent 30 percent of total Medicare expenditures. We met our goal for FY 2000 which was to provide States with all linked identifiers for dual eligible and make readily accessible supporting Medicare utilization data.

### **Assess the relationship between HCFA research investments and program improvements.**

The purpose of HCFA's research program is to provide HCFA and the health care policy community with objective analyses and information to develop, test and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States and other customers and partners.

HCFA partially achieved its FY 2000 goal, which was to conduct the first internal assessment of research achievements, and to have this internal assessment reviewed by an external panel.

## HCFA INITIATIVES

### **Program Integrity Strategy**

HCFA has implemented aggressive efforts to reduce fraud, waste, and abuse in the Medicare program. Increased funding, as well as new contracting authority allowing the agency to contract with new private entities for program integrity services, enabled HCFA to begin innovative approaches to program integrity. The Agency has maintained very high levels of return on investment, achieved significant Medicare savings and, perhaps more importantly, reduced the fee-for-service (FFS) error rate by half since 1996, from 14 percent in FY 1996 to 6.8 percent in FY 2000.

Our current program integrity strategy is two pronged. We direct our efforts to broad educational initiatives to assist providers in submitting claims that will be paid right the

first time. At the same time, we remain vigilant in our oversight of claims payment through data driven statistical analyses designed to stem fraud, waste and abuse. This strategy enables us to deploy our resources along three broad fronts:

- Increasing the focus of Agency and its claims processing contractors on provider education as a means to decrease errors.
- Identifying emerging vulnerabilities that have the biggest impact on our programs and targeting the appropriate medical review, audit or fraud investigation resources to address them.
- Continuing our partnership with law enforcement, through the Health Care Fraud and Abuse Control program, thereby helping to increase in convictions related to health care crime.

While we have made definite progress in our efforts to ensure proper payment, we must continue our vigilance and oversight of the Medicare program. Particular areas of focus include:

- Continuing efforts to reduce the error rate as we strive to achieve our 2002 GPRA goal of a 5 percent FFS error rate.
- Maintaining a focus on statistical measurement as a means of identifying and correcting payment errors.
- Continuing and enhancing the Agency's provider education efforts.
- Continuing our work-in partnership with law enforcement-to identify, halt and discipline those who would use the program solely for illegal gain.

### ***Strategies to Improve the Value of Error and Fraud Rates***

Our primary goal was to reduce the CFO audit Medicare fee-for-service payment error rate to 5 percent by 2002. The rate currently stands at 6.8 percent. We are developing methods to help us focus our efforts and resources to reduce payment error rates. The Comprehensive Error Rate Testing (CERT) program will produce a paid claims error rate at each contractor, by provider type, and service category levels. The Provider Compliance Rate (PCR) will provide an estimate of the accuracy of claims submitted by providers. A pilot Fraud Rate Project may enable Medicare contractors to determine the level of fraud prevalent among providers in their service areas. Additionally, a pilot Payment and Denial Verification Project conducted through HCFA's regional office in Boston will provide a more extensive review of a single contractor's claims and calculate error rates according to specific bill types. HCFA has included this as a FY 2001 GPRA goal.

### ***The Medicare Integrity Program (MIP)***

As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which established the "Medicare Integrity Program", HCFA can now competitively award contracts with entities to promote the integrity of the Medicare Program. The

competitive process ensures the highest quality for the best price, using appropriate clinical personnel. These specialized contractors with experience in program integrity activities will increase efficiency and effectiveness, and consistency in application of Medicare coverage and coding rules. Establishing organizations that focus on program safeguard activities separate from the mainstream of claims processing operations is a solution to a potential conflict of interest and a prudent business practice.

### ***Payment Error Prevention Program***

The Peer Review Organizations' (PROs) main goals are to improve quality of care for beneficiaries by ensuring that care meets professionally recognized standards, to protect the integrity of the Medicare program, and to protect beneficiaries through investigation of individual complaints and outreach and education activities.

Under the contracts that began in August 1999, HCFA has directed the PROs to increase their focus on ensuring Medicare hospital inpatient claims are billed and paid appropriately. As part of the Comprehensive Plan for Program Integrity, the PROs' Payment Error Prevention Program (PEPP) is focused at acute care hospitals operating under the Prospective Payment System. The PROs are slated to spend about 30 percent of their efforts on PEPP.

HCFA is developing a monitoring system to estimate the fee-for-service payment error rate independently within each State, or PRO area. This monitoring system will be continuous in nature and will produce periodic estimates. The PROs will be required to conduct an analysis to identify the nature and extent of payment errors occurring in their area. On the basis of this analysis, the PROs will be expected to implement appropriate educational interventions aimed at changing provider behavior and decreasing the observed payment error rate.

The incentives for PEPP will be an award bonus paid at the end of the contract period. It is based upon the reduction in payment error observed in each PRO area. The overall target for the three-year contract period is a 50 percent reduction in the payment error rate. The target will be adjusted for each PRO using the baseline payment error rate found in each State.

### ***Looking Towards the Future***

While we learn from the past, we will also spend a significant amount of resources and energy in adopting proactive strategies for integrity as we move into a Medicare modernized for the twenty-first century. We have instituted a new payment method for skilled nursing facilities and during FY 2000, we adopted new systems for outpatient departments and home health agencies. As we implemented these systems, we designed monitoring systems to ensure the accuracy of payments and provide more immediate feedback on errors to our providers. More vigorous oversight for nursing homes, enhanced standards for home health and durable medical equipment suppliers, a robust program for oversight of Medicare contractors, and new competitive projects for procuring services and supplies will help further strengthen the program and protect our beneficiaries.



### **Working with our Partners**

#### ***Medicare Fee-for-Service Contractors***

Medicare fee-for-service contractors play an important partnership role with HCFA in administering the Medicare program and safeguarding the fiscal integrity of the Medicare trust funds. HCFA assesses contractor performance through the Contractor Performance Evaluation (CPE) process with a goal of determining the extent to which contractors administer the Medicare program efficiently and economically, and meet their contractual obligations as required by law, regulation, contract, and HCFA directive.

In FY 2000, four Consortium Contractor Management Officers (CCMOs) were created to oversee the day-to-day management of Medicare fee-for-service contractors. The CCMOs work with regional office business function experts to jointly approve contractor budgets and to collaborate on other contractor management issues. Separating contractor management from contractor evaluation helps to maintain objectivity in the CPE process.

We contracted with a consulting firm to assist us in establishing a continuous improvement process for all aspects of CPE. With their assistance, we identified best practices and lessons learned from FY 1999 CPE reviews, and held a Lessons Learned conference in February 2000 to share this information with regional and central office staff involved in the CPE process. The consulting firm also documented and analyzed the entire CPE process and developed recommendations for improvement to the process. HCFA staff is currently analyzing these recommendations to incorporate into future CPE activities.

In addition, a number of changes have been made to the CPE process to further enhance the effectiveness and consistency of the oversight of Medicare fee-for-service contractors. The FY 2000 CPE plan was built on prior initiatives by employing risk analysis to prioritize contractors for review; developing and requiring the use of 13 standard functional area review protocols by all evaluators; and providing more prescriptive direction and training for reviewers on the planning, conduct, and reporting of CPE reviews. To further enhance the consistency of our evaluation activities, we increased the number of review teams comprised of central office and regional office staff to evaluate a broader array of business functions at a greater number of contractor locations.

The review teams consisting of central office and regional office staff conducted the following onsite reviews of critical business functions at higher risk contractors:

- Medical review, Medicare Secondary Payer, provider enrollment, benefits integrity, interim payment system reimbursement, accounts receivable, and overpayments were evaluated at selected fiscal intermediaries;
- Medicare Secondary Payer, medical review, benefits integrity, appeals, accounts receivable, provider enrollment, and overpayments were evaluated at selected carriers; and

- Fraud and abuse, quality, efficiency, and service were evaluated at the four Durable Medical Equipment Regional Carriers.

HCFA staff performed evaluations of certain other business functions at all fee-for-service contractors doing business with HCFA in FY 2000. The functional areas included mandated claims processing; customer service and payment safeguard standards; accounts receivable reporting; implementation of HCFA change management instructions; contractor customer service plans; audit quality of Medicare provider cost reports for fiscal intermediaries; and internal control reviews performed by independent public accounting firms at 25 contractors.

HCFA conducted performance improvement plan follow-up reviews to verify correction of deficiencies identified in prior year CPE activities, as well as corrective action plan reviews to follow-up on findings resulting from HCFA's FY 1999 financial statements audit.

We continued to improve the CPE management reporting process by again requiring the regional office submittal of plans for contractor evaluations in FY 2000, monthly status updates, and performance improvement plan tracking reports for FYs 1999 and 2000 deficiencies. To further streamline our CPE tracking and reporting process, we contracted with a consulting firm in FY 2000 to develop an intranet-based national CPE database to capture relevant CPE statistics and to simplify and standardize the CPE report preparation process.

In addition, HCFA is developing a strategic multi-year business plan for Medicare fee-for-service contractor operations. This is an important component for improving the management of Medicare contractors and strengthening HCFA's business partnership relationship with these contractors. This plan also supports future innovation in the Medicare program, such as changes in Medicare benefits and new delivery or payment structures.

### ***Medicaid Initiatives***

As part of the National Medicaid Fraud and Abuse Initiative, HCFA will continue to assist the OIG, the State Medicaid Fraud Control Units and Program Integrity Units in their role of identifying and sanctioning fraudulent providers. We ensure that all States are aware of fraudulent activities and scams occurring nationwide; promote consistency by establishing enhanced communications systems; form a National Fraud and Abuse Technical Advisory Group composed of HCFA and State agencies; and develop a model legislative fraud and abuse package for States that builds on the best practices of States who already have similar legislation. HCFA has also placed greater emphasis on Medicaid fraud through formation of the Medicaid Fraud and Abuse Coordinating Council and the Medicaid Regional Office Network.

### ***Partnering with States to Regulate Health Insurance***

HIPAA provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets. The law provides for

shared responsibilities for the Secretaries of HHS, Labor, and Treasury. HHS, through HCFA, is working with the other Departments in implementing the group market provisions. In addition, HCFA has the sole responsibility for implementing and overseeing the provision of insurance protection in the individual market.

The group market provisions of HIPAA affect group health plans. These HIPAA provisions are designed to improve the availability and portability of health coverage by limiting exclusions for preexisting conditions; providing credit for prior health coverage; providing new rights that allow some individuals to enroll for health coverage when they lose other coverage or have a dependent; prohibiting discrimination in enrollment and premiums; guaranteeing availability of health insurance coverage for small employers and renewability of coverage in both the small and large group markets.

HCFA issued four bulletins to clarify its position on insurers being prohibited from imposing nonconfinement clauses on eligible individuals; who qualifies as an "eligible individual" for purposes of obtaining health insurance coverage in the individual market; the relationship of certain types of State laws to the application of the guaranteed availability requirements of HIPAA; and the relationship between State "succeeding carrier" laws and the issuer's obligation under HIPAA to enroll an eligible individual who is hospitalized. Additionally, HCFA has helped hundreds of consumers resolve their HIPAA-related issues and exercise their rights under the statute.

In order to implement and enforce HIPAA provisions, HCFA, among other things, continues to collect and review documentation regarding policy forms for compliance, regulate certificates of prior creditable coverage, and monitor marketing of individual policies. We have been working closely with State officials so that workers and their families in these States can benefit from this law as soon as possible.

## **Improving the Health of Beneficiaries**

### ***Coverage***

One of HCFA's greatest challenges in administering the Medicare program is to maintain a dynamic decision making process that produces consistent coverage guidance in the face of rapid changes in medical technology and health care delivery. We are committed to having an open, understandable and predictable coverage process that assures access to medical advances for Medicare beneficiaries, while protecting them from services whose effectiveness is unproven.

Medicare has emerged as a leader in the move towards evidence-based decision making for coverage policy. We rely on state-of-the-art technology assessment and on agencies, such as the Agency for Healthcare Research and Quality, the Food and Drug Administration, the National Institutes of Health, the Department of Veterans Affairs, the Department of Defense as well as the advice of the medical community and private sector studies. Our own extensive Medicare and Medicaid data contain additional useful



information for assessing the effectiveness of all varieties of medical care. The experiences of the Medicare program can benefit the entire health care marketplace.

Medicare continues to develop and implement payment policies that are now being used in the private sector. This is in part due to the number of beneficiaries that we serve and the wealth of information available. Examples include prospective payment for inpatient hospitals, home health agencies and skilled nursing facilities, and the resource-based relative-value system for physician payment.

We have chartered an advisory committee that, when requested, will advise HCFA on national coverage issues. It holds open meetings and provides an opportunity for public participation on coverage issues referred to the committee. The committee is divided into small, clinically focused panels comprised of nationally recognized experts in a broad range of medical, scientific, and professional disciplines, as well as representatives of consumer and industry groups. The committee may review and evaluate medical literature, review technical assessments, and examine data and information on the effectiveness and appropriateness of medical items and services. Based on the evidence, the committee will advise and make recommendations to HCFA regarding coverage issues.

### ***Health Promotion and Prevention***

HCFA and the National Cancer Institute are working on a joint outreach campaign focused on increasing awareness of older women's risk for breast cancer and the importance of regular mammograms. The campaign known as "Not Just Once But for a Lifetime" encourages women eligible for Medicare to take advantage of yearly covered mammography screening. The specific target audiences for this year's campaign include Chinese, Korean, and Vietnamese women. The campaign will produce health promotion materials aimed at Asian-American women to increase awareness of their particular risk for breast cancer and their need to take advantage of the Medicare annual screening mammography benefit. The materials will be produced in several languages, as posters, bookmarks, and advertisements.

### ***End Stage Renal Disease (ESRD) Initiatives***

As the single largest purchaser of ESRD treatment services in the United States, HCFA has a critical responsibility for the quality of care delivered to these patients. Our challenge is to improve the quality and accessibility of the services, while keeping an eye on costs. We have successfully completed another year of data collection and reporting by the ESRD Clinical Performance Measures Project (formerly known as the ESRD Core Indicator Project). We are building a comprehensive, integrated approach to the quality management process for ESRD on a number of fronts. We are implementing a focused survey process, revising the Conditions for Coverage, developing ESRD clinical performance measures on quality of care, and enhancing the quality improvement projects of the ESRD Networks.

Additionally, we realize the need for collaboration between HCFA, the ESRD Networks, the State survey agencies, National Institutes of Health, United States Renal

Data System, United Network for Organ Sharing, and the renal community to develop a data management and analysis initiative, which will support quality measurement, as well as better monitoring management of ESRD patients. This initiative includes the development of a larger, more comprehensive database in a central repository that will be accessible and linked to HCFA and ESRD Network databases. Users will be able to access financial and clinical data on all ESRD Medicare beneficiaries.

We are also working to respond to comprehensive reports from the OIG and the General Accounting Office, as well as continuing interest from the Senate Special Committee on Aging on a wide variety of ESRD issues. These issues include using the new conditions to hold individual dialysis facilities more accountable for the care they provide, using existing enforcement authority more effectively, and making facility-specific data more available to consumers.

### ***Diabetes Quality Improvement Project***

The Diabetes Quality Improvement Project (DQIP) is a public-private sector quality improvement initiative, initiated and funded by HCFA. The objective of DQIP is to improve health care outcomes for individuals with diabetes. The private sector partners include in the American Diabetes Association, the National Committee on Quality Assurance, the Foundation for Accountability in Healthcare, the American Academy of Family Physicians, the American College of Physicians, and others. Federal partners include the Veterans Health Administration and the Centers for Disease Control. DQIP resulted in the first widely accepted comprehensive measure set for chronic disease that includes both process and outcome measures. Wide use of a single measure set allows valid comparisons of care across health care settings with meaningful opportunities to benchmark. Accountability of providers may also be improved by using the same measures. In FY 2000, some of the DQIP measures were reported for commercial, Medicaid, and Medicare managed care plans as part of HEDIS for American Diabetes Association Provider Recognition Program sites, and was collected by HCFA in all 50 States. Federal partners, e.g., the Indian Health Service, the Veterans Health Administration, and others will also be collecting and reporting the DQIP measures.

### ***Organ Donation Activities***

HCFA had several activities in FY 2000 designed to promote the Secretary's initiative to increase organ donations. Some examples included:

- Health Resources and Services Administration (HRSA) and HCFA published a resource guide, *Roles and Training in the Donation Process*, which can be used by hospitals and organ procurement organizations (OPOs) to train hospital staff to discuss donation with families of potential donors.
- HRSA and HCFA conducted two workshops to train hospitals and OPOs to effectively implement the hospital condition of participation for organ, tissue, and eye procurement. The workshops, held in March and July 2000, were attended by more than 250 people.

- HCFA's four regional consortia organ procurement organization (OPO) coordinators engaged in a variety of activities to increase organ donations. These activities included training of OPO staff and Medicare State hospital surveyors, sponsoring regional organ donation conferences, and speaking at national conferences.
- HCFA received and is analyzing the results of a Harvard School of Public Health study of a methodology for estimating the number of potential donors in hospitals.

### ***Nursing Home Initiative***

The President's nursing home initiative provides enhanced protections for nursing home residents. It targets needed improvements in nursing home quality through a number of enhancements to the survey and monitoring process. Changes to the survey process include more emphasis of care areas such as nutrition, hydration, pressure sores, unnecessary drugs and better interventions to prevent neglect and abuse in nursing homes. The initiative also calls for more frequent inspections of facilities that repeatedly violate standards, as well as staggered inspections on weekends and evenings to ensure uniformity in the quality of care. A HCFA campaign, which began in 1999, continues to raise awareness about detecting and reporting neglect and abuse in nursing homes under a theme of "Sometimes Abuse Is Not So Obvious." Certified Nursing Assistants are being targeted to increase their awareness of "Nutrition Care Alerts" and the action steps they can take to correct the situation.

### ***Hospital Quality Oversight***

In response to the recommendations of the Office of Inspector General's Final report entitled, "The External Review of Hospital Quality Oversight – A Call for Greater Accountability," HCFA continues to improve the oversight and quality of care in hospitals participating in the Medicare and Medicaid programs. Our initiative is designed to improve the accountability of accrediting organizations, the meaningfulness of survey information, and the systems for data collection and information sharing. Accomplishing this has included collaborating with the major accrediting agencies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA), as well as with State agencies. Some examples of these initiatives include:

In FY 2000, HCFA submitted the following final rules for HHS clearance: Certified Registered Nurse Anesthetist Supervision final rule, and the Quality Assessment and Performance Improvement Conditions of Participation (CoP) final rule.

As part of the Rhode Island Initiative, HCFA has been instrumental in establishing a Technical Advisory Group designed to develop and test hospital-specific performance measures based on the Peer Review Organization sixth Scope of Work.

HCFA has developed Patients' Rights CoP interpretive guidelines and survey procedures, which were effective May 2000 and held Surveyor Training in November 2000 on the Patients' Rights CoP.



HCFA has reevaluated the current process for oversight of the JCAHO and AOA and established accreditation oversight baseline information. Through the efforts of the central office and regional office oversight workgroup, we have revised the traditional hospital validation program to include observation and focused surveys and held Hospital Validation Surveyor Training in September 2000.

HCFA established a central office and regional office workgroup to investigate the current complaint process for accredited hospitals.

HCFA continues to examine the current reporting relationship for information sharing between HCFA, JCAHO and AOA.

HCFA has examined the current process for State Agency oversight and incorporated State Agency Quality Improvement Program activities into the larger strategy to evaluate State Agency performance using measurable and reportable performance standards.

### ***The Quality Improvement System for Managed Care (QISMC)***

QISMC is an effort to provide a coordinated, data driven quality improvement and oversight system for Medicare and Medicaid beneficiaries. As a part of the quality improvement system Medicare+Choice Organizations are required to report on HEDIS and Consumer Assessment of Health Plans Study (CAHPS) measures for purposes of comparative reporting to Medicare beneficiaries, address patient rights issues and undertake Quality Assessment and Performance Improvement Projects (QAPIs). Past national QAPI projects have been on diabetes and flu.

### ***Beneficiary Rights & Protections***

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a paper on the Consumer Bill of Rights and Responsibilities (CBRR) in November 1997. This document calls for a national effort to improve and sustain the quality of health care in the United States. We are working to ensure that health care programs are providing the full range of rights and protections to the recipients and beneficiaries of such programs. Two implemented regulations establish requirements for organizations participating in Medicare and strengthen protections for Medicaid beneficiaries enrolled in managed care arrangements.

HCFA published the Patients' Rights Condition of Participation (CoP) for hospitals. The CoP protects key patient rights and supports patient involvement in decision making. Included are the rights to privacy, safety, confidentiality of records, and the right to be free from unnecessary restraint or seclusion. The CoP also protects patients when restraint or seclusion is needed by requiring adequate patient monitoring, ending the intervention as quickly as possible, and training hospital staff in alternatives to restraint and seclusion. Guidelines released in May 2000 emphasize the need for individualized patient assessment and care.

The use of restraint and seclusion across care settings has been a focus of legislators and regulators for several years. Presently, HCFA is examining policies across care

settings to assure a consistent approach that supports freedom from restraint and seclusion and protects patients when their use is necessary.

### ***Clinical Trials Initiative***

Clinical trials are research studies designed to evaluate the safety and effectiveness of medical care. They are key to understanding the appropriate use of medical interventions of all types and informing payers about what services to cover. Previously, Medicare has not paid for items and services related to clinical trials because of their experimental nature. As a result, only a very small percentage of American seniors participate in clinical trials, although the elderly bear a disproportionate burden of disease in the United States.

In June 2000, the President issued an executive memorandum directing the Secretary of Health and Human Services to authorize Medicare payment for routine patient care costs and costs due to medical complications associated with participation in clinical trials. HCFA is engaged in defining the routine costs of clinical trials and identifying the clinical trials for which payment for such routine costs should be made.

## **Educating Beneficiaries for Value Based Decision Making**

### ***Defining Beneficiary Needs***

The Medicare Current Beneficiary Survey (MCBS) helps in monitoring and evaluating the health care needs of Medicare beneficiaries. It also helps us ensure that programs and services respond to the health care needs of our beneficiaries in a number of ways. It is a comprehensive source of information on the health, health care, socioeconomic, and demographic and other characteristics of aged, disabled, and institutional Medicare beneficiaries. It directly involves beneficiaries in defining their health care needs by interviewing a large representative sample of them about their health status and physical functioning, access to care, and satisfaction with the Medicare services they use. MCBS aids in HCFA's educational and outreach initiatives by collecting information to determine which methods are best suited to reaching specific subgroups of the Medicare population, and what the communication preferences are for the general Medicare population and several specific subgroups. The section of questions specific to beneficiary information initiatives has been refined and continued. These data help evaluate and continuously improve Agency communication activities.

In addition, HCFA is continuing the market research initiative. The inventory work of documenting beneficiary information needs and communication preferences for the general Medicare population and several specific subgroups has been completed. Reports of results are available. Also, consumer product testing is conducted on written beneficiary documents and we continue to obtain beneficiary input during the development of Agency programs and products. Finally, the agency has a new consumer research and communications contract with four prime contractors that can conduct the full range of communications activities.

### ***HCFA's Web Sites***

HCFA's data bases are the largest and most complete source of health care information in the United States. HCFA's Internet website, <http://www.hcfa.gov>, offers data, statistics, publications (including our annual financial report), guidelines on detecting fraud, and other material for our beneficiaries, contractors, providers, researchers, and the general public. [Http://www.hcfa.gov](http://www.hcfa.gov) has recently been expanded to include new activities, such as SCHIP and HIPAA. Although many beneficiaries do not have access to the Internet, beneficiary and consumer advocates, insurance counselors, and public entities who are the most frequent sources of beneficiary advice and counseling do possess this technology.

The [www.medicare.gov](http://www.medicare.gov) website is one of the keystones of HCFA's multifaceted beneficiary-centered public information program that has been designed to improve the quality of health care. Its target audience includes Medicare beneficiaries, caregivers, and advocacy groups. The site has evolved into an elaborate wealth of information, which is supported by a variety of interactive databases.

Several enhancements have been added to the site. HEDIS and CAHPS display health plan quality satisfaction information. "Nursing Home Compare" arrays the survey results of nursing homes for comparison by name and location. The "Important Contacts" database provides the phone number of any Medicare related agency in their state. "Medigap Compare," a database containing insurance information searchable by state and zip code, and the Outreach Calendar, a database containing the locations of health fairs and other information/education meetings and events, also searchable by state are also available. To compliment this array of information, Spanish, Chinese, large print and various other language and visual enhancements have been added to the site.

### ***National Medicare Education Program***

The National Medicare Education Program was implemented in 1998, using several channels to reach beneficiaries with accurate, consistent information on their health plan options, the basic Medicare program, beneficiary rights and protections, as well as issues of local concern such as plan terminations. The strategy included direct mail of the "Medicare & You 2000" handbook to all beneficiary households, a national toll free assistance line 1-800-MEDICARE (1-800-633-4227), and the [medicare.gov](http://medicare.gov) beneficiary website. The Regional Education About Choices in Health (REACH) Campaign, a nationally coordinated outreach campaign consisting of close to 2,000 localized activities was carried out by HCFA's regional offices. More than 3,000 outreach activities were held nationwide in FY2000 as part of the REACH campaign to increase awareness of Medicare+Choice, and Medicare issues.

Grants were also provided to 53 State Health Insurance Assistance Programs to support a counseling and assistance network of nearly 1,000 community level programs with over 12,000 volunteer counselors. The grantees include all 50 states and the District of Columbia, Puerto Rico and the Virgin Islands.



### ***Annual Publications***

The *"Medicare & You 2000"* handbook was mailed to 33 million beneficiary households nationwide. The handbook provides beneficiaries with information about Medicare and their health plan choices and is available in a variety of alternative formats, including Spanish, audio tape, large print and Braille.

HCFA and the National Association of Insurance Commissioners (NAIC) published the *"1999 Guide to Health Insurance for People with Medicare"* which provides detailed information on purchasing and using Medigap and other types of private health insurance. This Guide is available in English, Spanish, large print, Braille, and audio tape.

Many other publications were revised or introduced in 1999 including: **"Do You Need Help to Pay Health Care Costs?"**; **"Does Your Doctor or Supplier Accept Assignment?"**; **"Guide to Choosing a Nursing Home"**; **"Medicare Appeals and Grievances"**; **"Medicare Home Health"**; **"Medicare Hospice Benefits"**; **"Medicare Patient Rights"**; **"Medicare Private Fee-for-Service Plans"** and **"Medicare Coverage of Kidney Dialysis and Transplant Services"** was revised in 2000.

### ***Activities to Assist in Value-Based Purchasing***

We worked with the National Committee for Quality Assurance (NCQA) to adopt a system of Medicare and Medicaid quality measures called the HEDIS. In 1998 and 1999, we required more than 250 Medicare managed care risk and cost providers to report measures from HEDIS to the NCQA. These measures included effectiveness of care, use of services, access to care and other areas where we thought it important for HCFA as the largest purchaser of health care to have a better understanding of the performance of Medicare managed care plans. HCFA intends to combine HEDIS measures with other information that HCFA collects about health plans, such as beneficiary satisfaction, physician reimbursement arrangements, and disenrollment. For Medicaid, the States have the option of using those HEDIS measures that are most appropriate for their populations. HCFA is also exploring the feasibility of calculating selected effectiveness of care measures for its fee-for-service population.

### ***Other Value-Based Initiatives***

HCFA is participating in several other initiatives with non-Federal public purchasers, larger private purchasers, and purchasing coalitions. For example, HCFA has entered into cross-educational learning opportunities with General Motors Corporation, and General Electric regarding managed care organization oversight and quality initiatives.

HCFA has also incorporated private purchasing strategies such as quality assessment and performance improvement efforts for Medicare+Choice plans, risk adjustment payment strategies, disease management, and care coordination and competitive bidding concepts through demonstration efforts. Three examples are:

- The DME Competitive Bidding Demonstration uses market competition to help beneficiaries and the Medicare program obtain quality DME products in certain

categories at more reasonable rates. As in the private sector, the dynamics of the marketplace are expected to provide incentives for suppliers to offer quality DME items and services at competitive prices, resulting in savings for beneficiaries and the Medicare program. The initiative has been successful in protecting quality and access for beneficiaries while reducing the cost to beneficiaries and Medicare by an average of 17 percent compared to otherwise required Medicare rates for those products. A second demonstration is to be implemented in San Antonio in early calendar year 2001.

- Under the Competitive Pricing Demonstration, payments to managed care organizations in specified areas will be determined by a competitive pricing methodology. Two sites, Phoenix and Kansas City, have been selected to participate initially in this demonstration, but the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 delayed implementation of the demonstration until January, 2002, at the earliest. The Competitive Pricing Advisory Committee, comprised of health policy experts charged with making recommendations on the demonstration design and selecting demonstration sites, will soon submit a report to Congress on recommendations for potential demonstration changes.
- HCFA plans to implement a demonstration of new payment systems for cardiovascular and orthopedic surgery. Under this program, participating "Centers of Excellence" will be paid a negotiated bundled payment that will provide an incentive for hospitals and physicians to provide coordinated, cost-effective care. Beneficiaries and referring physicians will be encouraged to use these premier facilities, as they will provide high-quality care and additional benefits, while also providing lower costs to the Medicare program and beneficiaries. The demonstration will be conducted in Michigan, Illinois, and Ohio. Applications were sent to interested hospitals in January 2001.

## Electronic Data Processing

### *Standardizing Systems*

To become a more effective administrator of Medicare, our goal is to continue to work towards consolidating the Medicare payment systems into three standard systems, one for fiscal intermediaries, one for carriers and one for durable medical equipment carriers. This will simplify operations; enable HCFA to implement more effective change control processes, and ensure that the highest priority changes are made first. Consolidation of the durable medical equipment system was completed.

### *Information Systems Security*

HCFA's business needs and information technology capabilities are changing the way HCFA is doing business. We have an ever-expanding set of partners and customers; we want to conduct business more quickly using direct telecommunications; we have a presence on the Internet and wish to leverage its capabilities in greater ways. This



environment presents new opportunities, as well as new information systems security risks that HCFA must manage. We recognize that, with HCFA's missions increasingly dependent on information, a strong systems security infrastructure is essential to HCFA's success. A HCFA security initiative has been outlined and encompasses all aspects of HCFA information systems security: policy, administration, training, engineering, and oversight. The initiative establishes the structure for an evolving program to establish a technical and an administrative framework.

### ***Information Technology Investment Process***

HCFA's Financial Accounting and Control System replacement and the HCFA Integrated General ledger Accounting System projects are the first financial systems to be initiated under the IT Investment Process. In accordance with the Clinger-Cohen Act of 1996, HCFA developed a formal IT Investment Process. This process focuses on the selection, control, and evaluation of all IT projects, ensuring that they are implemented at acceptable costs, within reasonable time frames, and are contributing to tangible, observable improvements in mission performance. In conjunction with the IT Investment Process, HCFA has established a Technical Review Process for major IT investments. The process ensures that IT projects are developed consistent with the Agency's IT architecture standards (business, applications, infrastructure, information, security, and the governing policies and procedures). The process will promote effective workload management (enterprise scheduling and resource planning) for internal, external, and contractor resources required to deploy the IT application and/or system; and provide project owners with a clearly-defined process and a central focal point for involving IT professionals in the development of the project technical solutions.

## **FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS**

Since the first CFO audit of HCFA's financial statements, our goals have been to achieve an unqualified opinion or "clean opinion" from the auditors indicating that HCFA's financial statements are fairly presented in all material respects and to improve our internal controls and systems. Over the past several years, we have made tremendous strides in these endeavors as indicated by the clean audit opinion we received, for the second consecutive year, on the FY 2000 financial statements.

As an agency with one of the largest budgets in the Federal government, we recognize that we have a special obligation to ensure that each dollar we spend, whether for benefits or administration, is spent as wisely as possible. Therefore, HCFA's financial management operations are an integral aspect of HCFA's program and administrative activities. In this regard, HCFA's strategic vision for financial management is simple and direct: To develop and maintain a strong financial management operation to meet the changing requirements and challenges of the twenty-first century as we



continue to safeguard the assets of the Medicare trust funds. To accomplish this vision, we must improve financial reporting and contractor oversight to ensure reliable and accurate financial information is available to HCFA management and other decision makers. All of the financial management initiatives, projects, and activities we have identified are focused on meeting this challenge.

### **Chief Financial Officer Comprehensive Plan**

One of the more noteworthy accomplishments we achieved this year was the issuance of HCFA's first *Chief Financial Officer (CFO) Comprehensive Plan for Financial Management*. The Comprehensive Plan supports HCFA's strategic vision by outlining all of the activities we believe are necessary to ensure that we meet our responsibilities to our nation's citizens in establishing a strong and effective financial operation at HCFA. It contains 10 goals that are supported by 25 initiatives for achieving our strategic vision. The four key financial management objectives of our plan are to: 1) improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable HCFA managers and other decision makers to make timely and accurate program and administrative decisions; 2) design and implement effective management systems that comply with the Federal Financial Management Improvement Act (FFMIA); 3) improve debt collection and internal accounting operations; and 4) validate key financial data to ensure its accuracy and reliability.

The CFO Comprehensive Plan serves as our road map to improve financial management at HCFA, improve financial stewardship of the Medicare trust funds, and provides a clear statement against which progress can be measured. Additionally, to assist in our implementation of the CFO Comprehensive Plan, we created a senior leadership position within the Office of Financial Management, the Deputy Director for CFO Audits and Internal Controls (Deputy Chief Financial Officer), to provide a focal point for HCFA's financial management efforts.

### **CFO Audit**

For FY 1999, HCFA received its first clean audit opinion on its financial statements. While obtaining a clean opinion is an important objective, we recognize that additional efforts are necessary to continue financial management improvements. We need to take steps that continuously improve internal controls and the underlying financial reporting processes to ensure that we can generate accurate financial data on an on-going and timely basis. Our auditors continue to have concerns over many aspects of contractor financial reporting. One of the major issues remaining is the status of accounts receivable, most of which are maintained on our behalf by our fiscal intermediaries (FI) and carriers. These organizations, commonly referred to as Medicare contractors, have contracted with HCFA to administer the day-to-day operations of the Medicare program. They pay claims, audit provider cost reports, and establish and collect overpayments.

Because the systems used by the Medicare contractors have not always produced data that were adequately supported, our auditors have had difficulty validating their accounts receivable balances.

### ***Accounts Receivable***

To continue receiving a clean opinion we recognize that our financial statements have to properly reflect accounts receivable at their true economic value based on provisions provided within the Office of Management and Budget Circular A-129, ***Managing Federal Credit Programs***. Medicare accounts receivable are primarily provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) receivables which was comprised of paid claims that we subsequently determined that Medicare should have been the secondary rather than the primary payer.

While we have made progress and continue to make significant improvements in financial reporting, our auditors continue to report a material weakness in the Medicare accounts receivable area. HCFA's long term solution to addressing this material weakness is the implementation of the HCFA Integrated General Ledger Accounting System (HIGLAS) project. Until this project is implemented, HCFA will continue performing detailed reviews of Medicare contractors' financial data and internal controls to ensure proper accountability and management.

### **Revised Reporting Policy**

During FY 2000, we continued to perform extensive analysis of our delinquent debt, focusing on the likelihood of collection and the write-off of uncollectible debts. In addition, HCFA issued new policies on the reporting of delinquent debts to properly reflect accounts receivable balances at their true economic value. The policies provide for identification and write-off/adjustment of MSP settlement-related Group Health Plan (GHP) accounts receivable, MSP debt write-off of old uncollectible debt and referral of Non-MSP debt to debt collection centers under the Debt Collection Improvement Act of 1996 (DCIA). Revisions have also been completed on other policies regarding the definition of an accounts receivable including the treatment of unfiled cost reports and the allowance for uncollectible accounts, recognizing and reporting non-MSP currently not collectible (CNC) debt, and Medicare contractor financial reporting instructions.

### **Adjustments to Previously Reported Receivables**

In addition to issuing revised policies, we hired independent certified public accountants as consultants to review Medicare contractor accounts receivable balances in order to validate the receivable amounts reported to HCFA and the adequacy of their internal controls. For FY 2000, the consultants conducted reviews at 14 Medicare contractors, which comprised about 68 percent of the accounts receivable balance reflected in last year's financial statements. Additionally, we increased the scope of these reviews to include timely implementation of contractor corrective action plans (CAPs).

The consultants' reviews disclosed a total of \$201 million MSP and \$174 million non-MSP errors resulting in the accounts receivable being overstated by \$374 million.

While there is clearly room for improvement, these amounts indicate significant progress and reflect HCFA's continuing commitment to generate accurate financial statements.

### **Trend Analysis**

During FY 2000, we also hired consultants to assist us in developing analytical tools necessary to perform more expansive trend analysis of critical financial related data, specifically account receivables. These tools provide us the steps necessary to identify unusual variances and potential areas of risk. Additionally, the tools will allow us to readily perform more extensive data analyses, follow up with Medicare contractors, and determine the need for additional actions to ensure that problems are adequately resolved. These enhancements, along with additional staff members hired during FY 2000, allowed us to conduct trend analysis on quarter ending June 30 and September 30 data. During FY 2001, we expect to perform a more structured and robust financial analysis every quarter.

### ***Corrective Action Plans***

The annual CFO audits have helped to identify financial management and electronic data processing (EDP) weaknesses that limit our ability to effectively manage the Medicare program. Correcting these deficiencies is critical if we are to demonstrate our commitment to improving financial management and internal controls. Therefore, audit resolution is a top priority at HCFA. Medicare contractors, regional offices, and central office components are required to prepare a CAP for all deficiencies identified.

During FY 2000, we enhanced the CFO corrective action process to ensure that the contractors have appropriate CAPs for addressing all CFO findings. For the first time, a team of subject-matter experts comprised of HCFA central office and regional offices staff reviewed each contractor's proposed CAP related to financial management and internal control findings to determine if the corrective actions adequately addressed the reported deficiencies. Comments and suggestions regarding corrective actions that HCFA did not consider sufficient were provided to the contractors requesting them to revise their respective CAP. Each quarter the Medicare contractors submitted status reports on their corrective actions that were reviewed. Also, during FY 2000 the consultants, central office and regional office staff followed-up on contractor CAPs during the accounts receivable Contractor Performance Evaluation (CPE) reviews to ensure that problems were corrected. These actions should enhance our oversight and monitoring of contractors' efforts.

### **Debt Collection**

Historic collection data indicates that HCFA collects the majority of its debt because most overpayments are recognized timely, thus allowing future claims to be offset against current overpayments. Debts that are not collected within 180 days are subject to the Debt Collection Improvement Act (DCIA). Under the DCIA, Federal agencies are required to refer debts to the Treasury Offset Program (TOP) and to a designated Debt



Collection Center (DCC) for cross-servicing once they have become 180 days delinquent. Debts referred to the TOP are housed in the National Interactive Database and matched to Federal payments for potential offset. Debts referred to a DCC for cross-servicing can have a variety of collection activities including sending additional demand letters, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring some debts to the Department of Justice for litigation if necessary. The Department of Health and Human Services' Program Support Center (PSC) serves as the DCC for all MSP debts and a small portion of Non-MSP debts. The majority of Non-MSP debts are referred to Treasury, via the PSC, for cross-servicing and referral to TOP.

During FY 2000, HCFA implemented an accelerated debt referral pilot project that required the assistance of selected Medicare contractors and HCFA regional offices. The pilot entities forwarded customized demand letters to the delinquent debtors and input the debt information into the Agency's Debt Collection System to refer the debt electronically to the PSC and Treasury. As a result of the pilot, HCFA referred an additional \$1.7 billion of delinquent debt in FY 2000 to the PSC and Treasury for cross servicing and TOP. This brought the Agency's total delinquent debt referred to the PSC and Treasury to about \$2 billion by the end of FY 2000, which exceeded our goal by \$500 million.

HCFA will implement the accelerated debt referral process at all of its Medicare contractor locations in FY 2001. It is estimated that an additional \$2 billion of delinquent debt will be referred during FY 2001. HCFA's ultimate goal is to have 100 percent of its eligible delinquent debt referred for cross-servicing and TOP by the end of FY 2002.

### **Financial Management & Reporting**

One of the major benefits of the CFO Act has been to highlight the importance of accurate financial reporting and reliable internal controls. This has assisted us in identifying areas that need attention to ensure that we are presenting an accurate financial picture of HCFA.

#### ***Budget Execution***

We continue to improve our budget execution for the Program Management Appropriation. A Financial Management Investment Board (FMIB) comprised of senior staff representing each HCFA component has been established to recommend allocations of resources in support of Agency priorities. Final operating plan allocations are made by the Agency's Executive Council. In addition, we established lapse targets for each Program Management allotment, and managed funds aggressively to meet those targets. This ensured available funds were identified timely and allocated to fund Agency priorities.

#### ***Guidance to Medicare Contractors***

Medicare contractors provide much of the financial data HCFA uses to manage the Medicare program. The importance of ensuring that they are effectively managing

resources and reporting accurate financial data cannot be emphasized enough. Therefore, HCFA continued its efforts to hold Medicare contractors accountable for improved financial management. To emphasize the importance of their financial accountability, we required each Medicare contractor to establish a CFO position responsible for Medicare financial management activities and focus their attention on needed improvements.

HCFA also revised and clarified financial reporting and debt collection policies and procedures based on findings from CFO audits, oversight reviews, and Statement of Auditing Standards (SAS) -70 internal control reviews. The evaluation of findings resulting from these reviews allows HCFA to perform risk analysis and profiling of Medicare contractors to determine where our resources should be focused and where additional guidance is needed. Our goal is to continue to improve the consistency of information provided by the Medicare contractors.

We conducted two national training conferences for all the Medicare contractors and regional offices, with participation from the OIG, and contracted Certified Public Accounting (CPA) firms. We presented our revised policies and procedures for financial reporting and also emphasized the importance of documenting internal controls. With assurances that data is valid and complete, we have greater confidence in the accuracy and reliability of the financial information reported.

We also hired consultants to assist us in developing a Medicare contractor financial manual that will enhance contractors' ability to map their internal control environment and will assist HCFA in the development of training on internal control requirements. To ensure that our instructions are readily available and accessible, we are developing a database to be included on the HCFA Intranet and Internet that will contain all guidance and instructions issued. Additionally, this information will be consolidated with other useful financial management information, such as the annual Agency Financial Report, best practices, answers to frequently asked questions, and interim policy guidance, on a CFO Web page that is also planned for development. This Web page will provide useful links to other financial Web pages in the Federal government.

### ***Medicare Contractor Oversight***

Medicare contractors administer the day-to-day operations of the Medicare program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. Due to the materiality of this data, HCFA must have assurances as to its validity and accuracy. Therefore, HCFA established a number of initiatives that will improve the quality and consistency of financial data received from Medicare contractors. These initiatives are further enhanced by our trend analysis process.

#### **Internal Control Reviews**

During FY 2000, we contracted with CPA firms to conduct SAS - 70 internal control reviews of 26 Medicare contractors. The reviews indicated that 19 of 26 contractors reviewed had one or more findings, with a total of 116 findings identified. To ensure that

the findings are properly addressed in a timely manner, HCFA has requested that the contractors develop and submit CAPs. For FY 2001, reviews will be conducted at 13 contractors that were selected through a risk assessment. This effort will concentrate on four functional areas: EDP, claims processing, financial management, and debt collection.

### **Contractor Performance Evaluations (CPE) Program**

As part of HCFA's CPE program, accounts receivable reviews were conducted at almost all Medicare contractors. The purpose of these reviews was to ensure that the contractors have support and proper audit trails for accounts receivable data reported to HCFA. These reviews were either conducted by a local team comprised of regional office staff, a national team comprised of both central and regional office staff, or consultant CPA firms. Regardless of the type of team conducting the review, a standard review protocol was used to ensure the reviews are consistent. In addition, the contractors submitted Performance Improvement Plans or CAPs to address the findings identified.

In FY 2000, HCFA contracted with consultant CPA firms to perform accounts receivable reviews at 14 contractors comprising 68 percent of the accounts receivable balance. The scope of the review was also increased to include contractor implementation of CAPs. We also conducted national team reviews at three contractors with plans to increase the number of reviews to five for FY 2001. Regional offices reviewed the remaining contractors' accounts receivable balances.

### **HCFA-1522 Reconciliations**

The auditors continue to identify a material weakness in Medicare contractors' reconciliations of their HCFA-1522 Funds Expended Reports to their paid claims tapes. Monthly, contractors are required to submit this reconciliation to HCFA. During FY 2000, we developed a tool to track which contractors are submitting their 1522 reconciliations and issue reminder letters to contractors that have not.

### ***Financial Reporting***

In FY 2000, we continued to improve our financial statement reporting process within HCFA central office. During FY 2000, all financial data, including data provided by the Department of the Treasury and other Federal agencies, was included in HCFA's general ledger. This facilitated the preparation of the financial statements by eliminating manual entries into spreadsheets to determine necessary adjustments. It also provided the auditors with a clearer audit trail.

We are also exploring alternatives for an automated system for financial statement preparation. The objective is to be able to produce and rely upon formatted financial statements (for three of the five required statements) directly from the Financial Accounting and Control System (FACS) data base by June 30, 2001. This will enable the system to produce an audit trail documenting manual adjustments made to accounts that affect the financial statements. We also produced interim financial statements for the quarter ending June 30, 2000, and submitted our financial statements through the automated financial statement system implemented by the Department of Health and



Human Services for the second consecutive year. Additionally, for FY 2001 we plan to issue quarterly financial statements starting with March 31 data.

Our auditors also recognized our efforts to improve the reconciliation of financial data reported in our general ledger. Specifically, we developed validation techniques that provided our auditors with the necessary assurance that the calculation of Entitlement and Benefits Due and Payable was reasonable. In addition, the Office of the Actuary derives the accounts payable estimate, in part, from data maintained in the National Claims History (NCH) File. Our initiatives also developed trend analysis procedures to routinely monitor and validate data in the NCH File.

We have also complied with the Department of the Treasury's November 2000 reporting requirement for the Federal Agencies Centralized Trial Balance System (FACTS) II and the February 2001 reporting requirements for FACTS I.

We also improved the operation of FACS by programming and successfully implementing 96 accounting enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations.

### ***Medicare Secondary Payer***

Our efforts in the MSP area have again saved the Medicare trust funds approximately \$3 billion dollars. The categories of no fault insurance cases and liability savings showed a combined increase of \$31 million dollars or seven percent over the FY 1999 savings. During FY 2000, HCFA concentrated on increasing outreach efforts to attorneys in an effort to encourage self-reporting of potential mistaken payments. We continue to work with the Department of Justice to include repayments to the Medicare trust funds when a product liability suit is brought against a manufacturer. During FY 2000, HCFA made progress toward the recovery of funds from product liability litigation, such as Bone Screw, Heart Valves, Breast Implants and Fen-Phen.

### ***Other Initiatives***

In FY 2000, HCFA and its intermediaries continued to work with the home health industry to develop a strategy for dealing with the large amounts owed HCFA as a result of the Balanced Budget Act. We successfully met our objective to ensure repayment to the Medicare trust funds, while allowing home health agencies to continue providing services to Medicare beneficiaries.

For several years, the backlog of unsettled managed care cost reports has increased. In FY 1999, we reversed this trend and reduced the backlog of unsettled cost reports by approximately 63 percent. At the close of FY 2000, the total backlog of unsettled cost reports is down to 100; a reduction of about 50 percent. Disallowances resulting from these settlements amounted to \$40 million. In addition to these accomplishments, the audit program used by external CPA firms to perform these audits was revised to concentrate on areas of significant financial vulnerability to the Medicare program. Although we are currently experiencing a rate of return of 18 to 1, we project those numbers to increase in the future.

We also made important accomplishments in our administrative payment areas as well. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 98 percent of our vendor payments are paid electronically and 100 percent of travel and grant payments are paid electronically.

### **HCFA Integrated General Ledger Accounting System**

The FFMIA of 1996 broadened coverage of the CFO Act to require agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). The requirements of the FFMIA are also detailed in guidance from the Office of Management and Budget (OMB), specifically OMB Circular A-127 that requires Federal agencies to have an integrated financial management system. Although our CFO auditors have found that Medicare contractors claims processing systems are operating effectively in paying claims, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they do not meet the provisions of FFMIA.

Therefore, a key element of our strategic vision is to develop a FFMIA-compliant accounting system that will include all Medicare contractors. This project is entitled the HCFA Integrated General Ledger Accounting System (HIGLAS). As part of this effort, HCFA is also replacing the Financial Accounting Control System (FACS). FACS accumulates all of HCFA's financial activities, both programmatic and administrative, in its general ledger.

We are evaluating strategies for a system that will standardize the collection, recording, and reporting of Medicare financial information as well as satisfy Agency accounting needs. The ultimate goal is to implement and maintain a consolidated general ledger that produces supportable financial statements, with sufficient audit trails and provides meaningful financial data.

OMB Circular A-130, "Management of Federal Information Resources", requires that financial management systems development and implementation efforts seek cost effective and efficient solutions. Agencies must consider the use of commercial-off-the-shelf (COTS) software as the preferred alternative to reduce costs, improve the efficiency and effectiveness of financial system improvements projects, and reduce the risks inherent in developing and implementing a new system. HCFA intends to acquire a COTS product for HIGLAS that has been certified by the JFMIP, the selection of which will require approval by the Departments' Information Technology Acquisition Review Board (ITARB).

A HCFA-wide HIGLAS project team was formed under the leadership of the CFO and Chief Information Officer who oversee the project. During FY 2000, the team developed systems requirements, gap analysis and a concept of operations, and drafted the statement-of-work for the acquisition of a JFMIP approved COTS accounting system, a systems integrator, and an application service provider.

### ***Accounts Receivable Systems***

Last FY, it was noted that concurrent with the development of HIGLAS, HCFA was developing two accounts receivable systems. The requirements for the Medicare Accounts Receivable System have been completed. These requirements have been subsumed as a part of the overall requirements for the accounts receivable portion of the HIGLAS project. The accounts receivable module of HIGLAS will collect specific financial data relative to HCFA's account receivables reported by central and regional offices and Medicare contractors. The accounts receivable module will also facilitate the preparation of the Treasury Report on Receivables, which is sent to the Department of the Treasury on a quarterly basis.

The Recovery Management and Accounting System (ReMAS) will accumulate and report information on MSP debt and replace the numerous systems currently in use by Medicare contractors. ReMAS will perform the developmental work to determine an MSP receivable. Once the debt has been identified, it will be sent to HIGLAS for accounts receivable management.

## **Financial Statement Highlights**

### ***Consolidating Balance Sheet***

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by HCFA (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). HCFA's Consolidated Balance Sheet shows \$250 billion in assets. The bulk of these assets are in the Trust Fund Investments totaling \$217.6 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." The next largest asset is the fund balance of \$20.1 billion, most of which is for Medicaid and the State Children's Health Insurance Program (SCHIP). Liabilities of \$37.2 billion consist primarily of the Entitlement Benefits Due and Payable of \$36.5 billion. HCFA's net position totals \$212.7 billion and reflects the cumulative results of the Medicare trust fund investments and the unexpended balance for SCHIP.

### ***Consolidating Statement of Net Cost***

In FY 2000, the Consolidating Statement of Net Cost shows only a single amount: the actual net cost of HCFA's operations for the period by program. In prior year financial statements, earned revenues were deducted from expenses to arrive at the net cost of operations. The three major programs that HCFA administers are Medicare, Medicaid, and SCHIP. The bulk of HCFA's expenses are allocated to these programs.

Total Benefit Payments were \$334.6 billion for FY 2000. This amount includes estimated improper Medicare payments of \$7.5 to \$16.2 billion based on an audit by the



Office or the Inspector General. Administrative Expenses were \$2.2 billion, less than 1 percent of total Program/Activity Costs of \$339.1 billion.

The net cost of the Medicare program including benefit payments, Peer Review Organizations, Medicare Integrity Program spending, and administrative costs, was \$197 billion. Hospital Insurance (HI) Program Costs of \$126.9 billion were offset by \$1.4 billion in premiums. Supplementary Medical Insurance (SMI) Program Costs of \$87.8 billion were offset by premiums of \$20.5 billion. Medicaid Program Costs were \$118.6 billion. This represents expenses incurred by the States and Territories that were reimbursed by HCFA during the fiscal year, plus accrued payables. SCHIP Program Costs of \$1.3 billion for SCHIP are shown in the "Other" column.

### ***Consolidated Statement of Changes in Net Position***

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriations used of \$118.6 billion and \$74.7 billion in transfers from Payments to the Health Care Trust Funds to HI and SMI. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) for the HI trust fund totaling \$141.8 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to the Health Care Trust Funds) of \$65.3 billion, that matches monthly premiums paid by beneficiaries.

### ***Combined Statement of Budgetary Resources***

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as their status at the end of the year. HCFA's total budgetary resources were \$426.1 billion. Obligations of \$422.6 billion leave available unobligated balances of \$3.4 billion. Total outlays were \$413.1 billion. Net outlays were \$316.2 billion. The difference is comprised of \$75 billion in the Payments to the Health Care Trust Funds Appropriation, which is appropriated from the general fund into the SMI trust fund, then expended as benefit payments; and \$21.9 billion relating to collection of premiums.

### ***Combined Statement of Financing***

The Combined Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of HCFA's general ledger, which supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered

“funded” liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Combined Statement of Financing.

### ***Required Supplementary Stewardship Information***

As required by the Statement of Federal Financial Accounting Standards (SFFAS) Number 10, HCFA has included information about the Medicare Trust Funds – HI and SMI. The Required Supplementary Stewardship Information (RSSI) is a new requirement intended to assist users in evaluating operations and aid in assessing the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2000 Annual Report of the Board of Trustees of the Federal HI Trust Fund* and the *2000 Annual Report of the Board of Trustees of the Federal SMI Trust Fund*, which represent the official government evaluation of the financial and actuarial status of the Medicare Trust Funds.

### ***Limitations of the Financial Statements***

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990, (P.L. 101-576).

These financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by the Office of Management and Budget. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the **Budget of the U.S. Government** and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal control rests with management.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**

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# **Principal Statements and Notes**







**CONSOLIDATED BALANCE SHEET**

**As of September 30, 2000**

(in millions)

	Consolidated Totals
<b>ASSETS</b>	
<b>Intragovernmental Assets:</b>	
Fund Balance with Treasury (Note 2)	\$20,091
Trust Fund Investments (Note 3)	217,566
Accounts Receivable	484
FICA Tax Adjustment (Note 4)	1,313
Other Assets	
Anticipated Congressional Appropriation (Note 5)	6,561
<b>Total Intragovernmental Assets</b>	<b>\$246,015</b>
Accounts Receivable, Net (Note 6)	3,793
Interest and Penalties Receivable, Net (Note 6)	85
Advances to Grantees	2
Cash and Other Monetary Assets	61
Property, Plant and Equipment, Net	18
<b>TOTAL ASSETS</b>	<b>\$249,974</b>
<b>LIABILITIES (Note 9)</b>	
<b>Intragovernmental Liabilities:</b>	
Accrued Payroll and Benefits	\$4
Other Liabilities (Note 7)	427
<b>Total Intragovernmental Liabilities</b>	<b>431</b>
Accounts Payable	33
Entitlement Benefits Due and Payable (Note 8)	36,516
Federal Employee and Veterans' Benefits	10
Accrued Payroll and Benefits	66
Other Liabilities (Note 7)	187
<b>TOTAL LIABILITIES</b>	<b>\$37,243</b>
<b>NET POSITION</b>	
Unexpended Appropriations (Note 10)	\$14,119
Cumulative Results of Operations	198,612
<b>TOTAL NET POSITION</b>	<b>\$212,731</b>
<b>TOTAL LIABILITIES and NET POSITION</b>	<b>\$249,974</b>

The accompanying notes are an integral part of these statements.

# HCFA PRINCIPAL STATEMENTS AND NOTES 2000

## CONSOLIDATING STATEMENT OF NET COST

Year Ended September 30, 2000

(in millions)

	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
<b>NET PROGRAM/ACTIVITY COSTS</b>			
<b>GPRA Programs</b>			
Medicare <i>(Includes estimated improper payments of \$7.5-\$16.2 billion) (Note 11)</i>	\$197,041		\$197,041
Medicaid	118,705		118,705
SCHIP	1,273		1,273
<b>Net Cost - GPRA Programs</b>	<b>317,019</b>		<b>317,019</b>
<b>Other Activities</b>			
CLIA	(18)		(18)
Other	5		5
<b>Net Cost - Other Activities</b>	<b>(13)</b>		<b>(13)</b>
<b>NET COST OF OPERATIONS (Note 12)</b>	<b>\$317,006</b>		<b>\$317,006</b>

The accompanying notes are an integral part of these statements.

## CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

Year Ended September 30, 2000

(in millions)

	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
<b>NET COST OF OPERATIONS</b>	<b>\$317,006</b>		<b>\$317,006</b>
<b>Financing Sources</b> (other than exchange revenues):			
Appropriations Used	194,557		194,557
Taxes (and other non-exchange revenue) <i>(Note 13)</i>	156,252		156,252
Imputed Financing	23		23
Transfers-in			
Federal Matching Contributions <i>(Note 14)</i>	65,266	(65,266)	
Non-Expenditure Transfers-Benefit Payments	215,920	(215,920)	
Trust Fund Draws	1,983	(1,983)	
Other <i>(Note 15)</i>	10,337	(9,449)	888
Transfers-out			
Non-Expenditure Transfers-Benefit Payments	(215,920)	215,920	
Expenditure Transfers to Program Management	(1,983)	1,983	
Payments to Health Care Trust Funds	(74,715)	74,715	
Other <i>(Note 15)</i>	(1,018)		(1,018)
Other Revenues and Financing Sources			
Reclassification of Equity Accounts	36		36
<b>TOTAL FINANCING SOURCES</b>	<b>350,738</b>		<b>350,738</b>
<b>Net Results of Operations</b>	<b>33,732</b>		<b>33,732</b>
<b>Net Change in Cumulative Results of Operations</b>	<b>33,732</b>		<b>33,732</b>
Increase in Unexpended Appropriations <i>(Note 16)</i>	6,037		6,037
<b>Change in Net Position</b>	<b>39,769</b>		<b>39,769</b>
Net Position-Beginning of Period	172,962		172,962
<b>Net Position-End of Period</b>	<b>\$212,731</b>		<b>\$212,731</b>

The accompanying notes are an integral part of these statements.



**COMBINED STATEMENT OF BUDGETARY RESOURCES**  
**Year Ended September 30, 2000**

(in millions)

	<b>Combined Totals</b>
<b>Budgetary Resources:</b>	
Budget authority	\$450,090
Unobligated balances - beginning of period	1,423
Net transfers prior year balance, actual	(2)
Spending authority from offsetting collections	2,142
Adjustments	(27,536)
<b>TOTAL BUDGETARY RESOURCES</b>	<b>426,117</b>
<b>Status of Budgetary Resources:</b>	
Obligations incurred	422,628
Unobligated balances - available	3,359
Unobligated balances - not available	130
<b>TOTAL STATUS OF BUDGETARY RESOURCES</b>	<b>426,117</b>
<b>Outlays:</b>	
Obligations incurred	422,628
Less: spending authority from offsetting collections and adjustments	(5,243)
Obligated balance, net - beginning of period	13,236
Obligated balance transferred, net	
Less: obligated balance, net - end of period	(17,559)
<b>TOTAL OUTLAYS</b>	<b>\$413,062</b>

*The accompanying notes are an integral part of these statements.*

**COMBINED STATEMENT OF FINANCING**  
**Year Ended September 30, 2000**  
(in millions)

	Combined Totals
<b>RESOURCES USED TO FINANCE ACTIVITIES</b>	
<b>Budgetary</b>	
Budgetary resources obligated for orders, delivery of goods and services to be received, or benefits to be provided to others	\$422,628
Less: offsetting collections, and recoveries of prior-year authority	(5,336)
<b>Net Budgetary Resources Used to Finance Activities</b>	<b>417,292</b>
<b>Non-budgetary</b>	
Property received from others without reimbursement	1,978
Property given to others without reimbursement	(77,716)
Costs incurred by others for the entity without reimbursement	24
<b>Net Non-budgetary Resources Used to Finance Activities</b>	<b>(75,714)</b>
<b>TOTAL RESOURCES USED TO FINANCE ACTIVITIES</b>	<b>341,578</b>
<b>RELATIONSHIP of TOTAL RESOURCES to the NET COST of OPERATIONS:</b>	
Budgetary resources that fund expenses recognized in prior periods	35,302
Increase in budgetary resources obligated to order goods and services not yet received or benefits not yet provided	1,331
Adjustments other than collections made to compute net budgetary resources that do not affect net cost of operations:	
Recoveries of prior-year authority	(2,841)
Resources that do not affect net cost of operations	295
Anticipated transfers from Trust Funds	(110)
Resources that finance the acquisition of assets or liquidation of liabilities	4
<b>TOTAL RESOURCES USED TO FUND ITEMS NOT PART OF THE NET COST OF OPERATIONS</b>	<b>33,981</b>
<b>RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS</b>	<b>307,597</b>
<b>COMPONENTS NOT REQUIRING OR GENERATING RESOURCES</b>	
Expenses or exchange revenue related to the disposition of assets or liabilities, or allocation of their costs over time:	
Expenses related to use of assets	1,188
(Increase) in exchange revenue receivable from the public	(650)
(Increase) in Cash and Other Monetary Assets	(4)
Trust Fund Premiums collected	(21,907)
Other	(62)
Expenses that will be financed with budgetary resources recognized in future periods:	
Accrued Entitlement Benefit Costs	36,516
Less: budgetary resources currently available	<u>(5,690)</u>
Accrued Entitlement Benefit Costs, Net	30,826
Increase in Accrued Payroll and Benefits liability	3
Other	15
<b>TOTAL COMPONENTS NOT REQUIRING OR GENERATING RESOURCES</b>	<b>9,409</b>
<b>NET COST OF OPERATIONS</b>	<b>\$317,006</b>

*The accompanying notes are an integral part of these statements.*

# NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

## Reporting Entity

The Health Care Financing Administration (HCFA) is a separate financial reporting entity of the Department of Health and Human Services (HHS). The financial statements have been prepared to report the financial position and results of operations of HCFA, as required by the Chief Financial Officers Act of 1990. The statements were prepared from HCFA's accounting records in accordance with generally accepted accounting principles (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 97-01.

The financial statements cover all the programs administered by HCFA. The programs administered by HCFA are shown in two categories, Medicare and Health. The Medicare programs include:

### ***Medicare Hospital Insurance (HI) Trust Fund***

Medicare contractors are paid by HCFA to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. HCFA payments to managed care plans are also charged to this fund. The financial statements include HI Trust Fund activities administered by the Department of the Treasury (Treasury).

### ***Medicare Supplementary Medical Insurance (SMI) Trust Fund***

Medicare contractors are paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. HCFA payments to managed care plans are also charged to this fund. The financial statements include SMI Trust Fund activities administered by Treasury.

### ***Medicare Integrity Program (MIP)***

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP, codifying the program integrity activities previously known as "payment safeguards." This account is also called the Health Care Fraud and Abuse Control (HCFAC) Program, or simply "Fraud and Abuse." The MIP contracts with



eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI Trust Fund.

### ***Payments to the Health Care Trust Funds Appropriation***

The Social Security Act provides for payments to the HI and SMI Trust Funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of HCFA's administrative costs. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

### ***Permanent Appropriations***

A transfer of general funds to the HI Trust Fund in amounts equal to Self-Employment Contribution Act (SECA) tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries is made through 75X0513 and 75X0585, respectively. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 2000 are adjustments for late or amended tax returns. The Social Security Amendments of 1994, provided for additional tax payments from Social Security and Tier 1 Railroad Retirement beneficiaries.

The Health programs include:

#### ***Medicaid***

Medicaid, the health care program for low-income Americans, is administered by HCFA in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of HCFA's share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

#### ***The State Children's Health Insurance Program (SCHIP)***

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to implement SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are

issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

### ***Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund***

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

### ***Program Management User Fees: Medicare+Choice, Clinical Laboratory Improvement Program, and Other User Fees***

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program that requires managed care plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

### ***Program Management Appropriation***

The Program Management Appropriation provides HCFA with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI Trust Funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI Trust Fund to cover the Medicaid program's share of HCFA's administrative costs (see Note 12). User fees collected from managed care plans seeking Federal qualification and funds received from other federal agencies to reimburse HCFA for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated among all programs based on HCFA's cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Financial Statement Section.

### ***Basis of Presentation***

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), and amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from HCFA's general ledger in accordance with GAAP and the formats prescribed by the OMB Bulletin 97-01. Some amounts shown will differ from those in other financial documents, such as the **Budget of the U.S. Government** and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

### ***Basis of Accounting***

HCFA uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. The financial statements are prepared on an accrual basis. Individual accounting transactions are recorded using both the accrual basis and cash basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlaid. HCFA follows standard budgetary accounting principles that facilitate compliance with legal constraints and controls over the use of Federal funds.

HCFA uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

HCFA uses the cash basis of accounting in the Medicaid program to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to HCFA as of the end of the fiscal year.

### ***Consolidated Balance Sheet***

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by HCFA (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

#### **Assets**

**Fund Balances** are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. HCFA also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.



**Trust Fund Investments** are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

**Accounts Receivable, Net** consists of amounts owed to HCFA by other Federal agencies and the public. Amounts due are presented net of an allowance for uncollectible accounts.

**Medicare Secondary Payer (MSP) Accounts Receivable (A/R)** consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary payer. Receipts are transferred to the HI or SMI Trust Fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

**Medicare Non-MSP A/R** consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due, for example, excess payments that were determined to have been made once provider cost reports were audited. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI Trust Fund. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

**Advances to Grantees** are used to report advance payments made to health care providers. These occur when there are billing or claims processing problems and health providers ask for accelerated Medicare payments to minimize problems related to cash flow.

**Cash and Other Monetary Assets** are the total amount of time account balances at the Medicare contractors' commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

**Property, Plant and Equipment (PP&E)** are recorded at full cost of purchase, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, net of accumulated depreciation. All PP&E with an initial acquisition cost of \$25,000 or more and an estimated useful life of 2 years or greater is capitalized. PP&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

**Liabilities** represent amounts owed by HCFA as the result of transactions that have occurred. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI Trust Fund.

Liabilities covered by available budgetary resources include (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. HCFA recognizes such liabilities for employee annual leave earned but not taken, and amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments. For HCFA revolving funds, all liabilities are funded as they occur.

**Accounts Payable** consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

**Entitlement Benefits Due and Payable** represent Medicare or Medicaid medical services incurred but not paid as of September 30. The Medicare estimate is developed by the Office of the Actuary (OACT) and is based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimate represents (1) claims incurred that may or may not have been submitted to the Medicare contractors and were not yet approved for payment, (2) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (4) periodic interim payments, and (5) retroactive settlements of cost reports.

The Medicaid amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States.

**Federal Employee and Veterans' Benefits** consist of the actuarial portions of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and other post-employment benefits. These benefits programs are normally administered by the Office of Personnel Management (OPM) and not by HCFA.

**Accrued Payroll and Benefits** consist of Workers Compensation (FECA) payments due to the Department of Labor and the estimated liability for salaries, wages, funded annual leave and sick leave that has been earned but is unpaid.

**Other Liabilities** are the retirement plans utilized by HCFA employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to 7 percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable

to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

**Net Position** contains the following components:

*Unexpended Appropriations* include the portion of HCFA's appropriations represented by undelivered orders and unobligated balances.

*Cumulative Results of Operations* represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

### ***Consolidated Statement of Net Cost***

In FY 2000 the Consolidated Statement of Net Cost shows only a single amount: the actual net cost of HCFA's operations for the period by program. (In prior year displays, earned revenues were deducted from expenses to arrive at the net cost of operations. For FY 2000 this calculation appears in Note 12.) Under GPRA, HCFA is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that HCFA administers are: Medicare, Medicaid, and SCHIP. The bulk of HCFA's expenses are allocated to these programs. MIP is included in Medicare. The costs related to the Program Management Appropriation are cost allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown separately under "Other Activities."

Although the following terms do not appear in the Consolidated Statement of Net Cost, they are an integral part in the calculation of a program's net cost of operations:

**Program/Activity Costs** represent the gross costs or expenses incurred by HCFA for all activities.

*Benefit Payments* are the payments by Medicare contractors, HCFA, and Medicaid State agencies to health care providers for their services.

*Administrative Expenses* represent the costs of doing business by HCFA and its partners.

**Earned Revenues** or exchange revenues arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

*Premiums Collected* are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the



method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

**Net Cost of Operations** is the difference between the program's gross costs and its related exchange revenues.

### ***Consolidated Statement of Changes in Net Position***

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. Major components are described below.

**Financing Sources (Other than Exchange Revenues)** arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing.

**Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI Trust Fund in an amount equal to Self-Employment Contribution Act (SECA) tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

**Employment Tax Revenue** is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contributed the full 2.9 percent of their net income.

**Transfers-in/Transfers-out** report the transfers of funds between HCFA programs or between HCFA and other Federal agencies. Examples include transfers made from HCFA's Payment to the Health Care Trust Fund appropriation to the HI and SMI Trust Funds (which, in prior years, were reported as program costs) and the transfers between the HI and SMI Trust Funds and HCFA's Program Management appropriation. In FY 2000 the administrative payments made from HI and SMI to the Social Security Administration are reported as Transfers-out. In prior years, these payments were reported as Administrative Expenses.

### ***Combined Statement of Budgetary Resources***

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-HCFA

eliminations in this statement. HCFA was required to return the unobligated balance of the indefinite authority appropriated to Medicaid in the last quarter of FY 2000 to the general fund of Treasury.

**Unobligated Balances - beginning of period** represent funds available. These funds are primarily HI and SMI Trust Fund balances invested by the Treasury.

**Budget Authority** represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

**Obligations Incurred** consists of expended authority, recoveries of prior year obligations and the change in undelivered orders.

**Adjustments** are increases or (decreases) to budgetary resources. Increases include recoveries of prior year obligations; decreases include budgetary resources temporarily not available, rescissions, and cancellations of expired and no-year accounts.

### ***Combined Statement of Financing***

The Combined Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of HCFA's general ledger, which supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Combined Statement of Financing. Beginning FY 2000, the liability for services incurred but not reported in Medicaid contains a portion that is funded by budgetary resources. This portion is the unpaid grants awarded to the states, which creates a funded liability. Also, there are no intra-HCFA eliminations in this statement.

### ***Use of Estimates in Preparing Financial Statements***

Preparation of financial statements in accordance with Federal accounting standards requires HCFA to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

### ***Intra-Governmental Relationships and Transactions***

In the course of its operations, HCFA has relationships and financial transactions with numerous Federal agencies. For example, HCFA interacts with the Social Security

Administration (SSA) and Treasury. SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on HCFA's financial statements and the corresponding liabilities on the Treasury's financial statements are eliminated.

### ***Comparative Data***

The Technical Amendments to OMB Bulletin 97-01, "Form and Content of Agency Financial Statements" provides that comparative financial statements are permitted but not required until reporting periods beginning after September 30, 2000 (FY 2001). HCFA comparative financial statements are not presented for FY 2000.

### ***Estimation of Obligations Related to Canceled Appropriations***

As of September 30, 2000, HCFA has canceled over \$107 million in cumulative obligations to FY 1995 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FY 1996 through 2000 related to canceled appropriations, HCFA anticipates an additional \$1.6 million will be paid from current year funds for canceled obligations.



## NOTE 2: FUND BALANCES *(Dollars in Millions)*

	Entity Assets Unrestricted	Restricted	Consolidated Total
<b>Trust Funds</b>			
HI Trust Fund Balance (1)	\$(775)	\$13	\$(762)
SMI Trust Fund Balance (1)	847	3,129	3,976
<b>Revolving Funds</b>			
HMO Loan (2)	10		10
CLIA (2)	194		194
<b>Appropriated Funds</b>			
Medicaid	5,694		5,694
SCHIP	10,951		10,951
<b>Other Fund Types</b>			
HCFA Suspense Account (2)	14		14
Program Management Reimbursables (2)	14		14
<b>TOTAL FUND BALANCES</b>	<b>\$16,949</b>	<b>\$3,142</b>	<b>\$20,091</b>

(1) In HCFA's FY 1999 Financial Report, we reported that a series of miscalculations caused the HI Trust Fund to be underdrawn by about \$14 billion and the SMI Trust Fund to be overdrawn by about \$18 billion. At that time, we had projected (as a result of these miscalculations) that HI had earned excess interest of about \$154 million and SMI had lost interest earnings of about \$237 million for FY 1999. The mis-allocation of interest between the Medicare Trust Funds and the General Funds would result in a net loss of zero to the Federal government.

During FY 2000, HCFA's Office of the Actuary (OACT) determined that HI's excess interest earnings were actually \$111.6 million while SMI's shortfall in interest earnings was actually \$232.1 million. Subsequently, pursuant to P.L. 106-246 (Section 2703) the following actions were taken in August 2000:

- a) a total of \$111.6 million was redeemed from the HI trust fund and correspondingly invested in the SMI trust fund;
- b) the deficient amount of \$120.5 million was appropriated from the Treasury General Fund and invested in the SMI trust fund;
- c) the interest rates and maturity structures of the HI and SMI investments were adjusted so that the trust funds' assets would be restored as accurately as possible to the positions they would have been if the accounting errors in 1999 had not occurred.

The restricted portion of the HI and SMI fund balances represents the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI and SMI.

- (2) These fund balances are reported in the Supplementary Financial Statement section under the "All Others" column of the Consolidating Balance Sheet.

## NOTE 3: TRUST FUND INVESTMENTS, NET *(Dollars in Millions)*

### Medicare Investments

	Maturity Range	Interest Range	Value
<b>HI</b>			
Certificates	June 2001	6 - 6 1/4%	\$7,791
Bonds	June 2001 to June 2015	5 7/8 - 9 1/4%	161,068
Accrued Interest			2,877
<b>TOTAL HI INVESTMENTS</b>			<b>\$171,736</b>
<b>SMI</b>			
Certificates	June 2001	6 1/4%	\$729
Bonds	June 2001 to June 2015	5 7/8 - 8 3/4%	44,346
Accrued Interest			755
<b>TOTAL SMI INVESTMENTS</b>			<b>\$45,830</b>
<b>TOTAL MEDICARE INVESTMENTS</b>			<b>\$217,566</b>

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Consolidated Balance Sheet. This schedule summarizes the nature and amount of investments in the Medicare trust funds.

## **NOTE 4:**

### **FICA TAX ADJUSTMENT**

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Section 1817(a) of the Social Security Act requires that Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) taxes be transferred periodically from the general fund in Treasury to the HI Trust Fund. However, employers' reports of earnings subject to these taxes are only received by the Social Security Administration (SSA) quarterly and annually. As a result, the employment taxes transferred to the trust funds daily are initially based on estimates. These transfers are later adjusted as quarterly and annual employer reports of actual earnings amounts are received by the Internal Revenue Service and SSA, respectively. SSA certified to Treasury the amount of wages paid for December 2000 and prior quarters, the self-employment taxes collected for calendar year 1998 and prior, and the respective tax rates applicable. On the basis of this information, the HI Trust Fund was increased by \$1,313 million (accounts receivable) for FICA employment taxes transferred on the estimated basis and decreased by \$158 million (liability, see Note 7) for SECA taxes transferred on the estimated basis.

## **NOTE 5:**

### **ANTICIPATED CONGRESSIONAL APPROPRIATION**

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HCFA has recorded a \$6,561 million anticipated Congressional appropriation to cover liabilities incurred as of September 30 by the Medicaid program. Beginning in FY 1996, HCFA has accrued an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 2000, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of \$6,561 million. A review of appropriation language by HCFA's Office of General Counsel (OGC) has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, HCFA has recorded a \$6,561 million anticipated appropriation in FY 2000 for IBNR claims that exceed the available appropriation.



# NOTE 6:

## ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
<b>Provider &amp; Beneficiary Overpayments</b>					
Accounts Receivable Principal	\$5,112	\$1,740			\$6,852
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(2,717)</u>	<u>(1,016)</u>			<u>(3,733)</u>
Accounts Receivable, Net	2,395	724			3,119
<b>Medicare Secondary Payer (MSP)</b>					
Accounts Receivable Principal	134	90			224
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(112)</u>	<u>(78)</u>			<u>(190)</u>
Accounts Receivable, Net	22	12			34
<b>CMPs &amp; Other Restitutions</b>					
Accounts Receivable Principal	73	186			259
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(51)</u>	<u>(26)</u>			<u>(77)</u>
Accounts Receivable, Net	22	160			182
<b>Fraud and Abuse</b>					
Accounts Receivable Principal	101	110			211
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(100)</u>	<u>(109)</u>			<u>(209)</u>
Accounts Receivable, Net	1	1			2
<b>Managed Care</b>					
Accounts Receivable Principal	25	37			62
<u>Less: Allowance for Uncollectible Accounts</u>	<u>—</u>	<u>—</u>			<u>—</u>
Accounts Receivable, Net	25	37			62
<b>Medicare Premiums</b>					
Accounts Receivable Principal	127	250			377
<u>Less: Allowance for Uncollectible Accounts</u>	<u>(34)</u>	<u>(36)</u>			<u>(70)</u>
Accounts Receivable, Net	93	214			307
<b>Audit Disallowances</b>					
Accounts Receivable Principal	2	6	\$92		100
<u>Less: Allowance for Uncollectible Accounts</u>	<u>—</u>	<u>(1)</u>	<u>(13)</u>		<u>(14)</u>
Accounts Receivable, Net	2	5	79		86
<b>Other Accounts Receivable</b>					
Accounts Receivable Principal			13	\$1	14
<u>Less: Allowance for Uncollectible Accounts</u>			<u>(13)</u>	<u>—</u>	<u>(13)</u>
Accounts Receivable, Net				1	1
<b>TOTAL ACCOUNTS RECEIVABLE PRINCIPAL</b>	<b>5,574</b>	<b>2,419</b>	<b>105</b>	<b>1</b>	<b>8,099</b>
Less: Allowance for Uncollectible Accounts	(3,014)	(1,266)	(26)		(4,306)
<b>TOTAL ACCOUNTS RECEIVABLE, NET</b>	<b>\$2,560</b>	<b>\$1,153</b>	<b>\$79</b>	<b>\$1</b>	<b>\$3,793</b>

Medicare accounts receivable are primarily composed of provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount. Accounts receivable data were primarily obtained from data provided by the Medicare contractors.

### ***Currently Not Reportable/Currently Not Collectible Debt***

In FY 1999, HCFA implemented a number of policy changes in the reporting of delinquent accounts receivable. Provisions within the Office of Management and Budget (OMB) Circular A-129, *Managing Federal Credit Programs*, allow an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. The policy provides for certain debts to be written off closed without any further collection activity or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/Collectible). This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

In FY 2000, HCFA continued the implementation of this policy and again performed analyses of its accounts receivable. HCFA also continued to manage this debt by referring a significant portion of debt to Treasury for offset and cross-servicing in accordance with the Debt Collection Improvement Act of 1996.

### ***Recognition of MSP Accounts Receivable***

In FY 1999, HCFA reviewed its policy on the identification of MSP receivables to ensure that these debts are booked at the appropriate value and concluded that all MSP accounts receivable will continue to be recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance will reflect an adjustment for expected reductions to group health plan accounts receivable for situations where HCFA receives valid documented defenses to its recovery demands. In FY 2000, a similar adjustment was made.

### ***Write Offs and Adjustments***

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to HCFA's accounts receivable balance. HCFA's financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by HCFA to the Medicare contractors. The accounts receivable ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt and unfiled cost reports.

The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years.

### ***Non-entity Assets***

Assets are either "entity" (the reporting entity holds and has authority to use the assets in its operations) or "non-entity" (the reporting agency holds but does not have authority to use in its operations). Before FY 2000 HCFA reported its entity and non-entity assets in separate sections of the balance sheet. For FY 2000 HCFA is reporting its entity and non-entity assets in a single combined section.

The only non-entity assets on HCFA's Consolidated and Consolidating Balance Sheets are Interest and Penalties Receivable, Net for the amount of \$85 million.

## **NOTE 7:**

### **OTHER LIABILITIES** *(Dollars in Millions)*

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
<b>Intragovernmental:</b>						
Uncollected Revenue due Treasury	\$68	\$101			\$85	\$254
SECA Tax Adjustment <i>(see Note 4)</i>	158					158
Other	2	4	\$1		8	15
<b>TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES</b>	<b>\$228</b>	<b>\$105</b>	<b>\$1</b>		<b>\$93</b>	<b>\$427</b>
Deferred Revenue	\$31	\$117				\$148
Suspense Account Deposit Funds					\$15	15
Other	22	2				24
<b>TOTAL OTHER LIABILITIES</b>	<b>\$53</b>	<b>\$119</b>			<b>\$15</b>	<b>\$187</b>



## NOTE 8: ENTITLEMENT BENEFITS DUE AND PAYABLE *(Dollars in Millions)*

	Medicare		Total	Medicaid	Consolidated Total
	HI	SMI			
Medicare Benefits Payable (1)	\$12,671	\$11,481	\$24,152		\$24,152
Demonstration Projects and HMO Benefits	18	15	33		33
Medicaid Benefits Payable (2)				\$12,235	12,235
Medicaid Audit/Program Disallowances (3)				96	96
<b>TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE</b>	<b>\$12,689</b>	<b>\$11,496</b>	<b>\$24,185</b>	<b>\$12,331</b>	<b>\$36,516</b>

- (1) Medicare benefits payable consists of \$24.2 billion estimate by HCFA's Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2000.
- (2) Medicaid benefits payable of \$12.2 billion is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to HCFA as of September 30, 2000.
- (3) Medicaid audit and program disallowances of \$96 million are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HCFA. HCFA will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay approximately 36.8 percent of total contingent liabilities. Therefore, of the total contingent liabilities of \$261 million, HCFA expects to pay approximately \$96 million.

### ***Appeals at the Provider Reimbursement Review Board***

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 1999, there were 9,940 PRRB cases under appeal. A total of 4,013 new cases were filed in FY 2000. The PRRB rendered decisions on 90 cases in FY 2000 and 3,619 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 90 cases that were decided in FY 2000, a reasonable liability estimate cannot be projected for the value of the 10,244 cases remaining on appeal as of September 30, 2000.

As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

## NOTE 9: LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

	HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
<b>Intragovernmental:</b>						
Accrued Payroll and Benefits	\$1	\$3				\$4
<b>TOTAL INTRAGOVERNMENTAL</b>	<b>1</b>	<b>3</b>				<b>4</b>
Entitlement Benefits Due and Payable			6,641			6,641
Federal Employee and Veterans' Benefits	3	6	1			10
Accrued Payroll and Benefits	8	17	2			27
<b>TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES</b>	<b>12</b>	<b>26</b>	<b>6,644</b>			<b>6,682</b>
Total Liabilities Covered by Budgetary Resources	13,006	11,753	5,694		108	30,561
<b>TOTAL LIABILITIES</b>	<b>\$13,018</b>	<b>\$11,779</b>	<b>\$12,338</b>		<b>\$108</b>	<b>\$37,243</b>

## NOTE 10: UNEXPENDED APPROPRIATIONS *(Dollars in Millions)*

	HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
<b>Unobligated</b>						
Available					\$11	\$11
Unavailable	\$13	\$3,129				\$3,142
<b>Undelivered Orders</b>				\$10,951	15	10,966
<b>TOTAL UNEXPENDED APPROPRIATIONS</b>	<b>\$13</b>	<b>\$3,129</b>		<b>\$10,951</b>	<b>\$26</b>	<b>\$14,119</b>

## NOTE 11:

# MEDICARE BENEFIT PAYMENTS

### *Medicare Claims Estimated Improper Payments*

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. The claims submitted for payment to Medicare contractors contained no visible errors. However, when the medical review asked for documentation from providers to support their claims, there was a 6.8 percent error rate with a dollar value in the range of \$7.5-\$16.2 billion (\$11.9 billion midpoint). The majority of the errors fell into four broad categories: lack of medical necessity, insufficient or no documentation, incorrect coding, and noncovered/unallowable services.

### *Cost Report Settlement Process*

The cost report settlement process represents the value of final outlays to providers based on fiscal intermediary (FI) audits, reviews and final settlements of Medicare cost reports. All institutional providers are required to file Medicare cost reports. For providers paid under the prospective payment system (PPS), the cost report includes costs that are not covered under PPS, such as disproportionate share hospital payments, indirect medical education payments, and other indirect costs. For providers paid on a cost basis, the cost report represents the total costs incurred by the provider for medical services to patients and reflects the final distribution of these costs to the Medicare program.

In 2000, 34,576 cost reports totaling \$103.7 billion were reviewed. Approximately \$82.9 billion represented inpatient claims to PPS providers. These inpatient claims were included in prior years' claims testing that resulted in the determination of the Medicare claims improper payment error rate. The cost report settlements, therefore, focused on the remaining non-PPS balance of about \$20.8 billion.

### **2000 Cost Report Summary**

(Dollars in millions)

	<b>Desk Reviews and Other</b>	<b>Audits</b>	<b>Total</b>
Cost Reports	28,923	5,653	34,576
Costs Claimed	\$40,713	\$63,027	\$103,740
Disallowed	\$857	\$1,449	\$2,306



The \$2.3 billion disallowed represents 11 percent of the \$20.8 billion non-PPS balance. Based on the current disallowance rates, if the full-scope audits were expanded to include the entire universe, the total amount disallowed would range from \$2.3 billion to \$2.9 billion. Therefore, by limiting the amount of full-scope audits that were conducted, HCFA may have overpaid providers by as much as \$570 million.

### Potential Liability

HCFA routinely processes and settles cost reports for institutional providers. As part of this process some providers have filed suits challenging aspects of the cost report settlement process. HCFA cannot reasonably estimate the probability of the providers successfully winning their suits nor the potential liability for the Department. However, in the opinion of management, the resolution of these matters will not have a material impact on the results of operations and financial condition of HCFA.

## NOTE 12: TOTAL PROGRAM ACTIVITY COSTS *(Dollars in Millions)*

(By Object Class)

	Medicare		Total	Medicaid	SCHIP	CLIA	All Others	Consolidated Total
	HI	SMI	Medicare					
<b>PROGRAM COSTS</b>								
<b>Medicare</b>								
Insurance Claims and Indemnities								
Fee for Service	105,446	69,462	\$174,908					\$174,908
Managed Care	21,495	18,332	39,827					39,827
<b>Medicaid and SCHIP</b>								
Grants and Subsidies				\$118,564	\$1,268			119,832
<b>TOTAL PROGRAM COSTS</b>	<b>\$126,941</b>	<b>\$87,794</b>	<b>\$214,735</b>	<b>\$118,564</b>	<b>\$1,268</b>			<b>\$334,567</b>
<b>OPERATING COSTS</b>								
Administrative								
Personal Services and Benefits	\$139	\$184	\$323	\$21	\$1			\$345
Contractual Services	734	966	1,700	103	4			1,807
Grants and Subsidies	6	11	17	1				18
Travel and Transportation	4	6	10	1				11
Rental and Utilities	11	21	32	2				34
Printing and Reproduction	2	3	5					5
Supplies and Materials	1	2	3					3
Equipment	7	12	19	1				20
<b>TOTAL ADMINISTRATIVE COSTS</b>	<b>\$904</b>	<b>\$1,205</b>	<b>\$2,109</b>	<b>\$129</b>	<b>\$5</b>			<b>\$2,243</b>
Depreciation and Amortization	\$2	\$4	\$6	\$1				\$7
Bad Debts and Writeoffs	608	568	1,176	6				1,182
Medicare Integrity Program	865		865					865
Imputed Cost Subsidies	7	15	22	2				24
CLIA Program Costs						\$122		122
Reimbursable Costs							\$8	8
Other Costs	14	25	39	3				42
<b>TOTAL COSTS</b>	<b>\$129,341</b>	<b>\$89,611</b>	<b>\$218,952</b>	<b>\$118,705</b>	<b>\$1,273</b>	<b>\$122</b>	<b>\$8</b>	<b>\$339,060</b>
<b>Less: EARNED REVENUES</b>								
Premiums Collected	\$(1,392)	\$(20,515)	\$(21,907)					\$(21,907)
Other Earned Revenues	(4)		(4)			\$(140)	\$(3)	(147)
<b>NET COST OF OPERATIONS</b>	<b>\$127,945</b>	<b>\$69,096</b>	<b>\$197,041</b>	<b>\$118,705</b>	<b>\$1,273</b>	<b>\$(18)</b>	<b>\$5</b>	<b>\$317,006</b>

## HCFA PRINCIPAL STATEMENTS AND NOTES 2000

For purposes of financial statement presentation, non-HCFA administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the SSA reported \$78.2 million of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 2000. This amount is not included in HCFA's Consolidated Balance Sheet as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 2000 to pay for this activity are included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by Treasury. These expenses are also reported by SSA on their FY 2000 Annual Financial Statement. HCFA's administrative costs have been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include \$1.1 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

The chart below details the Administrative Expenses by agency. HCFA is only one of several agencies that charge some administrative expenses to Medicare.

### Administrative Expenses

(Dollars in millions)

	Medicare			Medicaid	SCHIP	Consolidated Total
	HI	SMI	Total			
<b>Administrative Expenses by Agency</b>						
Treasury	\$40		\$40			\$40
HCFA	629	\$1,161	1,790	\$129	\$5	1,924
Peer Review Organizations	235	44	279			279
<b>TOTAL ADMINISTRATIVE EXPENSES</b>	<b>\$904</b>	<b>\$1,205</b>	<b>\$2,109</b>	<b>\$129</b>	<b>\$5</b>	<b>\$2,243</b>

## NOTE 13: TAXES AND OTHER NON-EXCHANGE REVENUE *(Dollars in Millions)*

	Medicare HI	SMI	Medicaid	SCHIP	All Others	Consolidated Total
FICA Tax Receipts	\$132,475					\$132,475
SECA Tax Receipts	9,283					9,283
Trust Fund Investment Interest	10,824	\$3,455				14,279
Deposits by States	2					2
Criminal Fines	57					57
Civil Monetary Penalties and Damages	148					148
Administrative Fees	4					4
Other Income	1	3				4
<b>TAXES AND OTHER NON-EXCHANGE REVENUE</b>	<b>\$152,794</b>	<b>\$3,458</b>				<b>\$156,252</b>

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

## NOTE 14: PREMIUMS COLLECTED AND FEDERAL MATCHING CONTRIBUTION

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was \$45.50 from October 1999 through September 2000. Premiums collected from beneficiaries totaled \$20.5 billion in FY 2000 and were matched by a \$65.3 billion contribution from the Federal government.



# NOTE 15:

## OTHER TRANSFERS-IN/OUT *(Dollars in Millions)*

Transfers-in	Medicare HI	SMI	Combined Total	Intra-HCFA Eliminations	Consolidated Total
Fraud and Abuse Appropriation	\$76		\$76	\$(76)	
Transfer-Uninsured Coverage	470		470	(470)	
Program Management Admin. Expense (1)	116		116	(116)	
Military Service Contribution	63		63		\$63
Income Tax OASDI Benefits (2)	8,787		8,787	(8,787)	
Railroad Retirement Principal	823		823		823
Gifts and Miscellaneous	1	\$1	2		2
<b>TOTAL OTHER TRANSFERS-IN</b>	<b>\$10,336</b>	<b>\$1</b>	<b>\$10,337</b>	<b>\$(9,449)</b>	<b>\$888</b>

Transfers-out	Medicare HI	SMI	Combined Total	Intra-HCFA Eliminations	Consolidated Total
SSA Administrative Expenses: Annual Year	\$(479)	\$(489)	\$(968)		\$(968)
SSA Administrative Expenses: No Year	(9)	(21)	(30)		(30)
Office of the Secretary	(5)	(4)	(9)		(9)
Payment Assessment Commission	(4)	(3)	(7)		(7)
Railroad Retirement Board		(4)	(4)		(4)
<b>TOTAL OTHER TRANSFERS-OUT</b>	<b>\$(497)</b>	<b>\$(521)</b>	<b>\$(1,018)</b>		<b>\$(1,018)</b>

(1) During FY 2000, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund \$116 million to cover the Medicaid and SCHIP programs' share of HCFA's administrative costs.

(2) The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of Old Age Survivors and Disability Insurance (OASDI) benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent. The revenues, resulting from this increase, are transferred to the HI Trust Fund.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 2000, a total of \$1,983 million was obtained from the trust funds to cover cash outlays. Of this amount, \$1,503 million was needed to pay for expenses incurred against current year obligations and \$480 million (of which \$61 million was transferred to the CLIA program) was needed for expenses incurred against prior year obligations.

## NOTE 16: INCREASE (DECREASE) IN UNEXPENDED APPROPRIATIONS *(Dollars in Millions)*

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Consolidated Total
Current Year Warrants and Anticipated Appropriations Exceeding (Less Than) Appropriated Capital Used	\$(21)	\$3,129	\$(60)	\$2,991	\$(2)	\$6,037
<b>TOTAL INCREASE (DECREASE) IN UNEXPENDED APPROPRIATIONS</b>	<b>\$(21)</b>	<b>\$3,129</b>	<b>\$(60)</b>	<b>\$2,991</b>	<b>\$(2)</b>	<b>\$6,037</b>

The unexpended appropriations increased due to the FY 2000 Payment to the Health Care Trust Funds and SCHIP appropriations' exceeding FY 2000 expenditures.

## NOTE 17: GROSS COST AND EXCHANGE REVENUE BY BUDGET FUNCTIONAL CLASSIFICATION *(Dollars in Millions)*

	Medicare	Health	Combined Total	Intra-HCFA Eliminations	Consolidated Total
Intragovernmental Costs	\$247	\$29	\$276		\$276
With the Public	<u>218,705</u>	<u>120,079</u>	<u>338,784</u>		<u>338,784</u>
Gross Cost	218,952	120,108	339,060		339,060
Less: Exchange Revenue	(21,911)	(143)	(22,054)		(22,054)
<b>NET COST</b>	<b>\$197,041</b>	<b>\$119,965</b>	<b>\$317,006</b>		<b>\$317,006</b>

## NOTE 18: SUBSEQUENT EVENT - TRANSFER TO TITLE XIX AS REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR MEDICAID EXPANSION SCHIP SERVICES

An Amendment to the State Children's Health Insurance Program (SCHIP) was passed on December 21, 2000 that allows for Medicaid expansion of the SCHIP services paid by Title XIX (Medicaid) to be reimbursed from amounts appropriated under Title XXI (SCHIP) for expenditures incurred for fiscal year 1998 through 2000. This reimbursement will be accomplished in fiscal year 2001. The total Medicaid Expansion SCHIP expenditures incurred in fiscal year 1998 through 2000 is about \$1.2 billion. The financial statements have not recognized a receivable for Medicaid and a related liability for SCHIP in the Consolidating Balance Sheet for this reimbursement since there was no legal authority at September 30 to record such reimbursement.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**

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# **Required Supplementary Stewardship Information**







## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for more than three decades. A brief description of the provisions of Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs is included on pages 3-5 of this financial report.

The required supplementary stewardship information (RSSI) contained in the following sections is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSSI material is generally drawn from the *2000 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* and the *2000 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, which represent the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

Printed copies of the Trustees Reports may be obtained from HCFA's Office of the Actuary (410-786-6386). The reports are also available online at [www.hcfa.gov/pubforms/tr/hi2000/toc.htm](http://www.hcfa.gov/pubforms/tr/hi2000/toc.htm) and [www.hcfa.gov/pubforms/tr/smi2000/toc.htm](http://www.hcfa.gov/pubforms/tr/smi2000/toc.htm).

Please note that the 2000 Trustees Reports for HI and SMI (issued March 31, 2000) were used as source documents for this FY 2000 CFO Financial Report. As this report goes to print, we anticipate that the Government-wide financial statement report for FY 2000 (expected to be issued March 31, 2001) will contain updated information from the 2001 Trustees Reports (which are expected to be issued on or near March 15, 2001). Thus, some data related to the Medicare Trust Funds contained in this FY 2000 CFO Financial Report may differ from that contained in the FY 2000 Financial Report of the United States Government.

## ACTUARIAL PROJECTIONS

### Cashflow in Nominal Dollars

Using nominal dollars<sup>1</sup> for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that the mind can comprehend in today's experience.

<sup>1</sup> Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

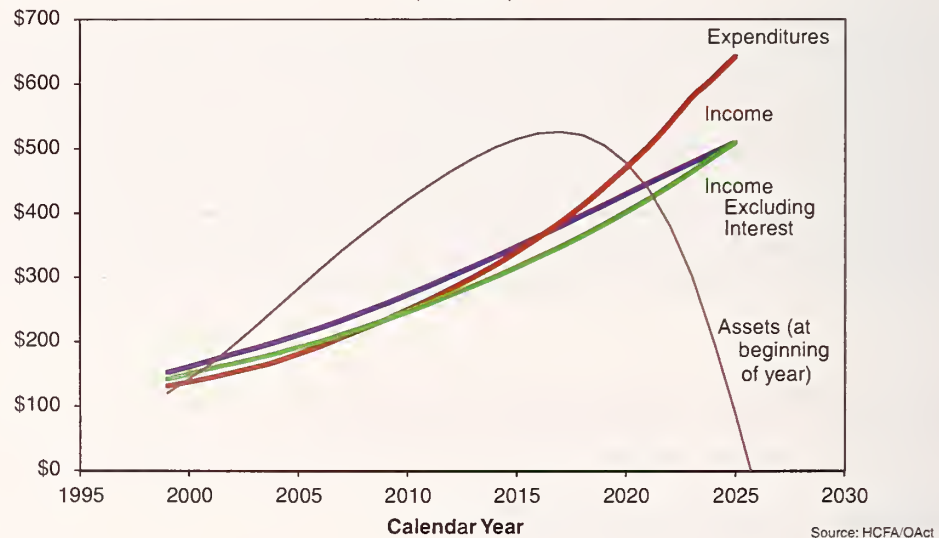
## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2025. Estimates for the SMI program are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is in automatic financial balance every year.

### HI

Chart 1 shows the actuarial estimates of HI income, disbursements, and assets for each of the next 25 years, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the trust fund, and other miscellaneous revenue. Disbursements include benefit payments and administrative expenses. The estimates are for the “open group” population—all persons who will participate in the program during the period as either taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 25 years. The estimates also include expenditures attributable to these current and future workers, in addition to current beneficiaries.

**Chart 1—HI Income, Expenditures, and Assets**  
**1999-2025**  
(In billions)



As chart 1 shows, under the intermediate assumptions HI expenditures would begin to exceed income including interest in 2017 and income excluding interest in 2010. This situation is primarily due to the retirement, starting in 2010, of those born during the 1945-1965 baby boom. Beginning in 2017, the trust fund would start redeeming trust fund assets; in 2025, the assets would be depleted.

The projected year of depletion of the trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion.



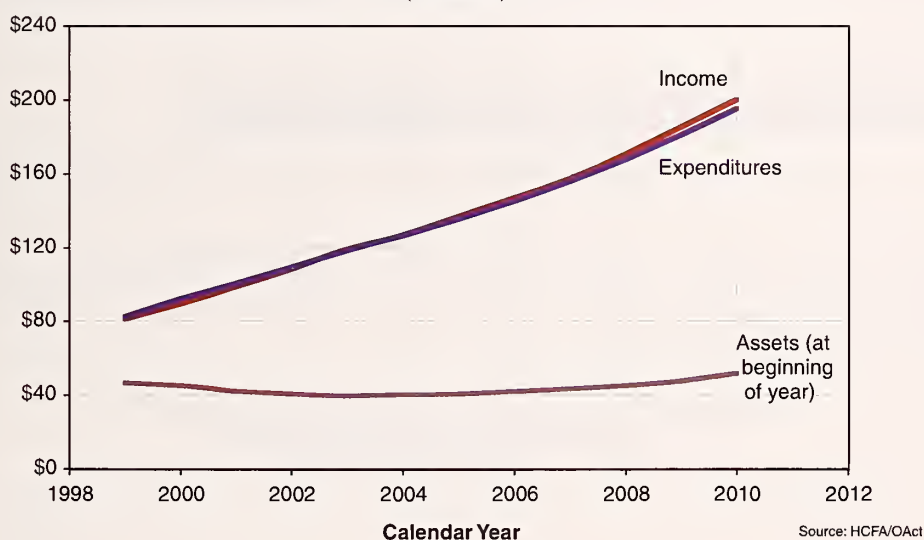
## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

### SMI

Chart 2 shows the actuarial estimates of SMI income, disbursements, and assets for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2025, SMI estimates cover only the next 10 years, as the SMI program differs fundamentally from the HI program in regard to the way it is financed. In particular, SMI financing is not at all based on payroll taxes but instead on monthly premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not projected separately beyond 10 years.

Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, and interest earned on the U.S. Treasury securities held by the trust fund.<sup>2</sup> Chart 2 displays only total income; it does not represent income excluding interest. The difference between the two is not visible

**Chart 2—SMI Income, Expenditures and Assets**  
**1999 - 2010**  
(In billions)



graphically since interest is not a significant source of income.<sup>3</sup> Disbursements include benefit payments as well as administrative expenses.

<sup>2</sup> In this financial statement for the Health Care Financing Administration, Medicare income and expenditures are shown from a "trust fund perspective." All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual *Financial Report of the United States Government*, also known as the consolidated financial statement. On a consolidated basis, the estimates are shown from a "Federal budget" perspective. In particular, certain categories of trust fund income—primarily interest payments and SMI general revenues—are excluded because they represent intragovernmental transfers, rather than revenues received from the public. Thus, the consolidated financial statement focuses on the overall balance between revenues and outlays for the Federal budget, rather than on the financial status of individual trust funds.

<sup>3</sup> Interest income is generally about 4 percent of total income.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

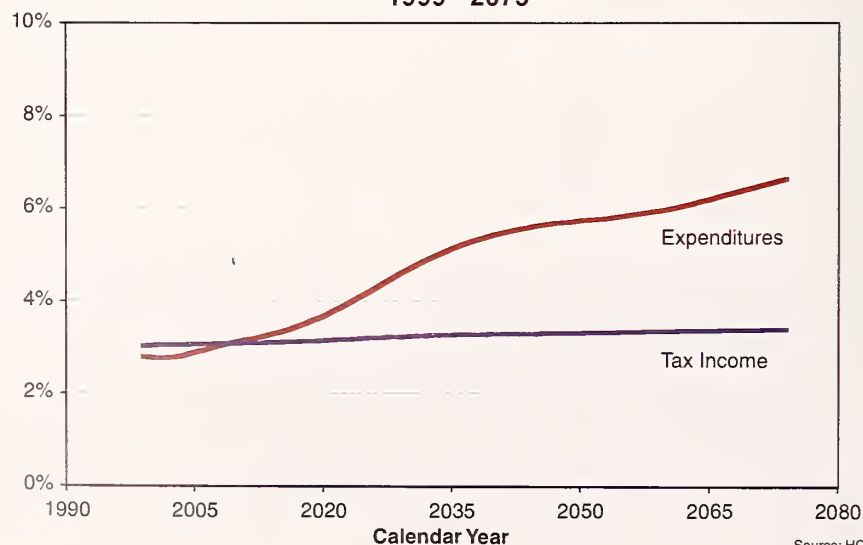
As chart 2 indicates, SMI income is very close to expenditures. As noted earlier, this is due to the financing mechanism of the SMI program. Consequently, under present law, the SMI program is automatically in financial balance every year, regardless of future economic and other conditions.

By law, Medicare trust fund assets are invested in special U.S. Treasury Securities, which earn interest while Treasury uses those cash resources for other Federal purposes. During times of Federal “on-budget” surpluses, such as fiscal year 2000, this process reduces the Federal debt held by the public. In times of Federal budget deficits, Medicare surpluses reduce the amount that must be borrowed from the public to finance those deficits. Unlike the assets of private pension plans, the trust funds do not consist of real economic assets that can be sold in the future to fund benefits. Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing other Federal expenditures. (When financed by borrowing, the effect is to defer today’s costs to later generations who will ultimately repay the funds being borrowed for today’s Medicare beneficiaries.) The existence of large trust fund balances, therefore, represents an important obligation for the Government to pay future Medicare benefits but does not make it easier for the Government to pay those benefits.

### HI Cashflow as a Percent of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI program are prepared for the next 75 years. Because of the difficulty in comparing dollar values for different periods without some type of relative scale, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under the HI program (referred to as “taxable payroll”).

**Chart 3—HI Income Excluding Interest and Expenditures  
as a Percentage of Taxable Payroll  
1999 - 2075**



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Chart 3 illustrates income excluding interest and expenditures as a percent of taxable payroll over the next 75 years. Although the long-range financial outlook for the HI program has improved substantially in recent years as a result of the Balanced Budget Act of 1997, favorable economic conditions, and efforts to curb fraud and abuse, the program remains seriously underfunded through 2075. This is due in part to health care cost increases that exceed wage growth; a more significant cause, however, is the impending retirement of those born during the 1945-1965 baby boom.

Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll will remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, projected expenditures as a percent of taxable payroll sharply escalate between 2010 and 2035 and continue to increase throughout the period.

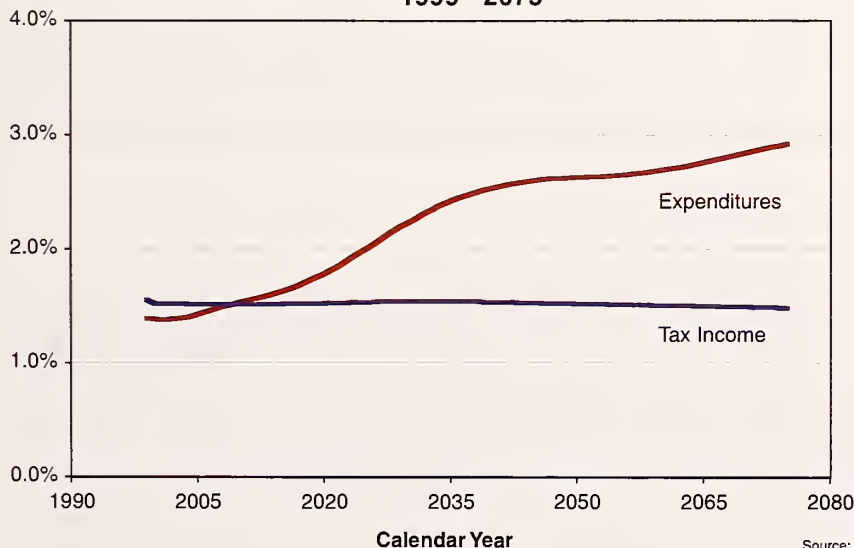
### HI and SMI Cashflow as a Percent of GDP

Expressing Medicare incurred disbursements as a percentage of the gross domestic product (GDP) gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

#### HI

Chart 4 shows income excluding interest and expenditures for the HI program over the next 75 years expressed as a percentage of GDP. In 1999, the expenditures were \$131.4 billion, which was 1.40 percent of GDP. This percentage increases steadily throughout the entire 75-year period.

**Chart 4—HI Income Excluding Interest and Expenditures as a Percent of GDP  
1999 - 2075**



Source: HCFA/OAcl



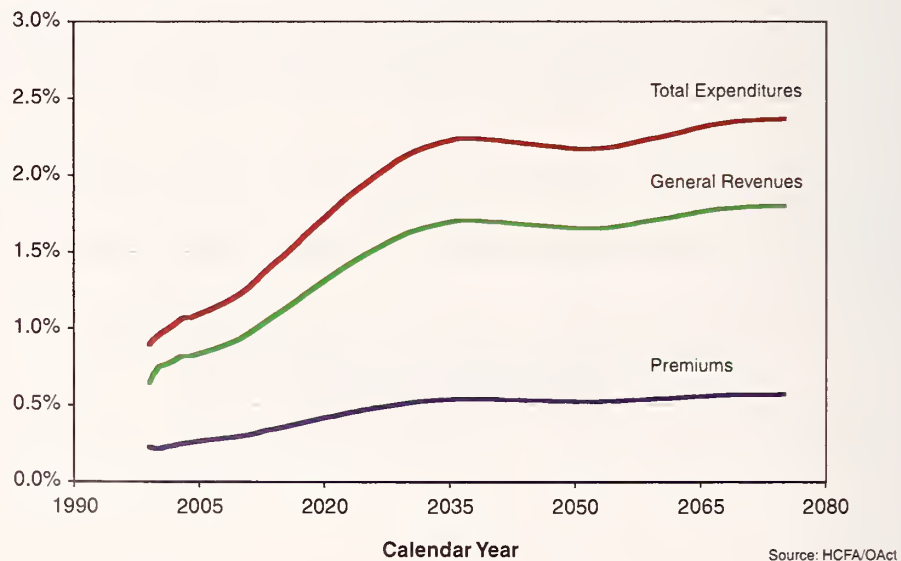
**SMI**

As noted earlier, because of the SMI financing mechanism in which income mirrors expenditures, it is not necessary to display income and expenditures separately. Rather, it is more important to examine the projected rise in expenditures.

Chart 5 shows expenditures for the SMI program over the next 75 years expressed as a percentage of GDP. In 1999, SMI expenditures were \$80.5 billion, which was 0.89 percent of GDP. This percentage is projected to increase steadily through 2035, reflecting growth in the price, utilization, and intensity of SMI services that is expected to exceed GDP growth for many years, together with the effects of the baby boom retirement. After 2035 it levels off because SMI projections by assumption are tied directly to GDP and because the relatively fewer number of persons born after the baby boom will be eligible for SMI benefits.<sup>4</sup>

Also shown in chart 5 are the proportions of total costs that will be met through beneficiary premiums and general revenues under present law.<sup>5</sup> As indicated, premiums will cover roughly 25 percent of total expenditures.

**Chart 5—SMI Expenditures as a Percent of GDP  
1999 - 2075**



<sup>4</sup> For SMI, increases in the costs per enrollee during the initial 25-year period are assumed to gradually decline in the last 12 years to the same rate as GDP per capita and then to continue at the same rate as GDP per capita in the last 50 years.

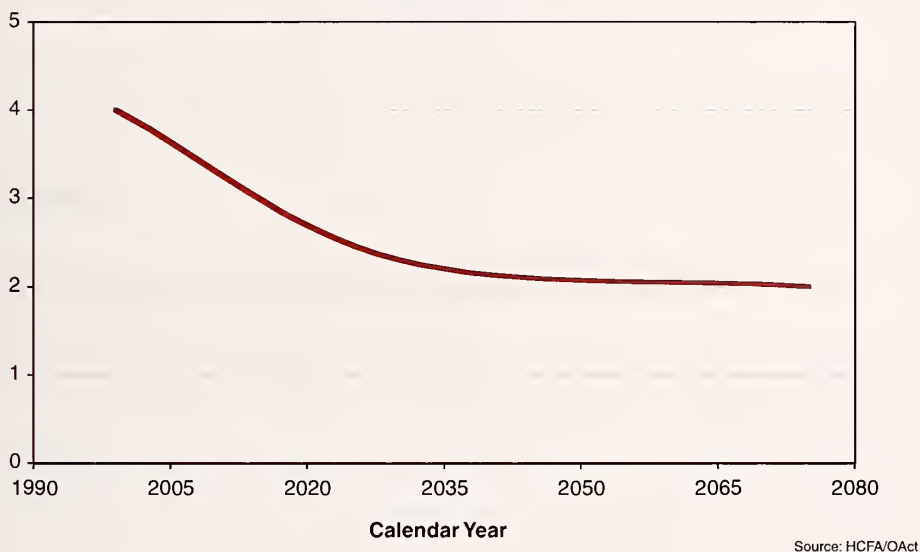
<sup>5</sup> See footnote 2 regarding the treatment of SMI general revenue income in the consolidated financial statement of the U.S. government.

## Worker-to-Beneficiary Ratio

### HI

Another way to evaluate the long-range outlook of the HI program is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 1999, every beneficiary had 4.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary in 2070.

**Chart 6—Number of Covered Workers per HI Beneficiary  
1999 - 2075**



## ACTUARIAL PRESENT VALUES

Projected future expenditures can be summarized by computing an “actuarial present value.” This value represents the lump-sum amount that, if invested today in trust fund securities, would be just sufficient to pay each year’s expenditures over the next 75 years, with the fund being drawn down to zero at the end of the period. Similarly, future revenues (excluding interest) can be summarized as a single, equivalent amount as of the current year.

Actuarial present values are calculated by discounting the future annual amounts of non-interest income and expenditures at the assumed rates of interest credited to the HI and SMI

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

trust funds. Present values are computed as of the beginning of the 75-year projection period for three different groups of participants: current workers and other individuals who have not yet attained retirement age; current beneficiaries who have attained retirement age; and new entrants, or those who are expected to become participants in the future.

Table 1 sets forth, for each of these three groups, the actuarial present values of all future HI and SMI expenditures and all future non-interest income for the next 75 years. Also shown is the net present value of cashflow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income.

**TABLE 1**  
**Actuarial Present Values of Hospital Insurance and**  
**Supplementary Medical Insurance Revenues and Expenditures:**  
**75-year Projection as of January 1, 2000**  
(In billions)

<i>Actuarial present value<sup>1</sup> of estimated future <u>income</u> (excluding interest) received from or on behalf of:</i>	HI	SMI <sup>2</sup>
Current participants <sup>3</sup> who, at the start of projection period:		
Have not yet attained eligibility age (ages 15-64)	\$3,757	\$6,109
Have attained eligibility age (age 65 and over)	97	934
Those expected to become participants (under age 15)	3,179	1,616
All current and future participants	<b>7,033</b>	<b>8,659</b>
<i>Actuarial present value<sup>1</sup> of estimated future <u>expenditures</u><sup>4</sup> paid to or on behalf of:</i>		
Current participants <sup>3</sup> who, at the start of projection period:		
Have not yet attained eligibility age (ages 15-64)	\$6,702	\$6,094
Have attained eligibility age (age 65 and over)	1,681	1,051
Those expected to become participants (under age 15)	1,349	1,514
All current and future participants	<b>9,732</b>	<b>8,659</b>
<i>Actuarial present value<sup>1</sup> of estimated future income (excluding interest) less expenditures</i>	-2,700	0
Trust fund assets at start of period	141	45
<i>Assets at start of period plus actuarial present value<sup>1</sup> of estimated future income (excluding interest) less expenditures</i>	<b>-2,558</b>	<b>45</b>

<sup>1</sup> Present values are computed on the basis of the intermediate set of economic and demographic assumptions specified in the Report of the Board of Trustees for the year shown and over the 75-year projection period beginning January 1 of that year.

<sup>2</sup> SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of the beneficiaries. See footnote 2 on page 79 concerning treatment of SMI general revenues in the consolidated financial statement of the U.S. government.

<sup>3</sup> Current participants are the "closed group" of individuals age 15 and over at the start of the period. The projection period for these current participants would theoretically cover all of their working and retirement years, a period that could be greater than 75 years in some instances. As a practical matter, the present values of future income and expenditures from/for current participants beyond 75 years are not material. The projection period for new entrants covers the next 75 years.

<sup>4</sup> Expenditures include benefit payments and administrative expenses.

*Note: Totals do not necessarily equal the sums of rounded components.*



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

As shown in table 1, the HI program has an actuarial deficit of more than \$2.5 trillion over the 75-year projection period. On the other hand, SMI does not have similar problems because it is in automatic financial balance every year due to its financing mechanism. The existence of a large actuarial deficit for the HI trust fund indicates that, under reasonable assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures in the long range. Although the deficits are not anticipated in the immediate future, as indicated by the preceding cashflow projections, they nonetheless pose a serious financial problem for the HI program.

It is important to note that no liability has been recognized on the balance sheet for future payments to be made to current and future program participants beyond the existing unpaid Medicare claim amounts as of September 30, 2000. This is because Medicare is accounted for as a social insurance program rather than a pension program. Accounting for a social insurance program recognizes the expense of benefits when they are actually paid, or are due to be paid, because benefit payments are primarily nonexchange transactions and, unlike employer-sponsored pension benefits for employees, are not considered deferred compensation. Accrual accounting for a pension program, by contrast, recognizes retirement benefit expenses as they are earned so that the full actuarial present value of the worker's expected retirement benefits has been recognized by the time the worker retires.

## ACTUARIAL ASSUMPTIONS AND SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI programs, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that the programs will continue under present law. In addition, the estimates depend on many economic and demographic assumptions, including changes in wages and the consumer price index (CPI), fertility rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period.

Table 2 shows some of the underlying assumptions used in the projections of Medicare spending displayed in this report. Further details on these assumptions are available in the OASDI, HI, and SMI Trustees Reports for 2000. In practice, a number of specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, etc.). These assumptions include changes in the utilization, volume, and intensity of each of these types of service. The per beneficiary cost increases displayed in table 2 reflect the overall impact of these more detailed assumptions.

# REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

**Table 2**  
**Medicare Assumptions**

	<i>Annual percentage change in:</i>								
	Fertility rate <sup>1</sup>	Net immigration	Real wage differential <sup>2</sup>	Wages	CPI	GDP	<i>Per beneficiary cost</i> <sup>3</sup>		Real Interest rate <sup>4</sup>
2000	2.05	900,000	1.5	4.6	3.1	3.5	HI	SMI	3.6
2005	2.03	900,000	1.0	4.2	3.3	2.0	5.3	6.2	2.9
2010	2.01	900,000	1.0	4.3	3.3	2.1	4.4	6.0	3.0
2020	1.97	900,000	1.0	4.3	3.3	1.7	3.9	4.9	3.0
2030	1.95	900,000	1.0	4.3	3.3	1.7	5.2	4.7	3.0
2040	1.95	900,000	1.0	4.3	3.3	1.7	5.3	4.4	3.0
2050	1.95	900,000	1.0	4.3	3.3	1.7	4.4	4.1	3.0
2060	1.95	900,000	1.0	4.3	3.3	1.7	4.5	4.6	3.0
2070	1.95	900,000	1.0	4.3	3.3	1.7	4.8	4.4	3.0

<sup>1</sup> Average number of children per woman.

<sup>2</sup> Difference between percentage increases in wages and the CPI.

<sup>3</sup> See text for nature of this assumption.

<sup>4</sup> Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

Estimates made in prior years have sometimes changed substantially because of revisions to the assumptions, which are due either to changed conditions or to more recent experience. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty. In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.<sup>6</sup> The assumptions varied are the fertility rate, net immigration, real-wage differential, CPI, real-interest rate, and health care cost factors.<sup>7</sup>

For this analysis, the intermediate economic and demographic assumptions in the *2000 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2000 and are based on estimates of income and expenditures during the 75-year projection period.

<sup>6</sup> Sensitivity analysis is not done for the SMI program due to its financing mechanism. Any change in assumptions would have no impact on the net cashflow since the change would affect income and expenditures equally.

<sup>7</sup> The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per-beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity. The Health Care Financing Administration is sponsoring a current research effort by the Rand Corporation that is expected to provide the information necessary to produce such estimates.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2025 under all three scenarios displayed. On the present value charts, the same pattern is evident, though the magnitudes are lower because of the discounting process used for computing present values.

### Fertility Rate

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 1.95, and 2.2 children per woman.

**Table 3**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Fertility Rate Assumptions**

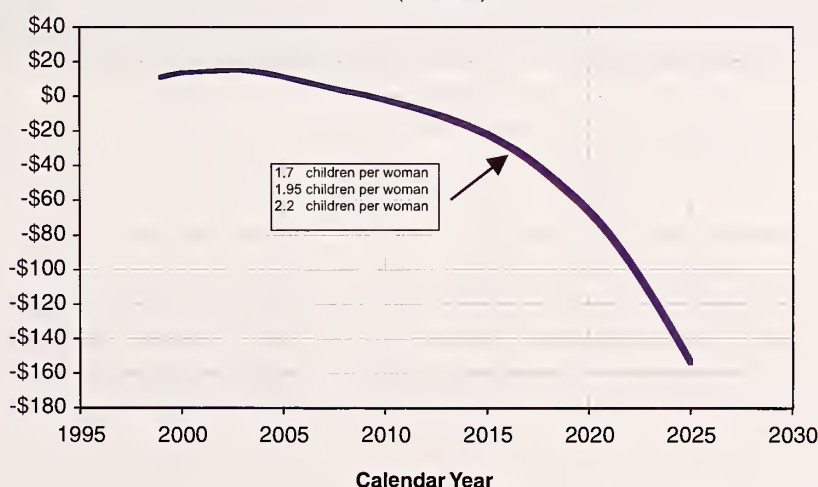
Ultimate fertility rate <sup>1</sup>	1.7	1.95	2.2
Income minus expenditures	-\$2,830	-\$2,700	-\$2,575

<sup>1</sup> The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire childbearing period.

Table 3 demonstrates that if the assumed ultimate fertility rate is decreased from 1.95 to 1.7, the projected deficit of income over expenditures increases from \$2,700 billion to \$2,830 billion. On the other hand, if the ultimate fertility rate is increased from 1.95 to 2.2 children per woman, the deficit decreases to \$2,575 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 3.

**Chart 7—HI Net Cashflow with Various Ultimate Fertility Rate Assumptions**  
**1999 - 2025**  
(In billions)



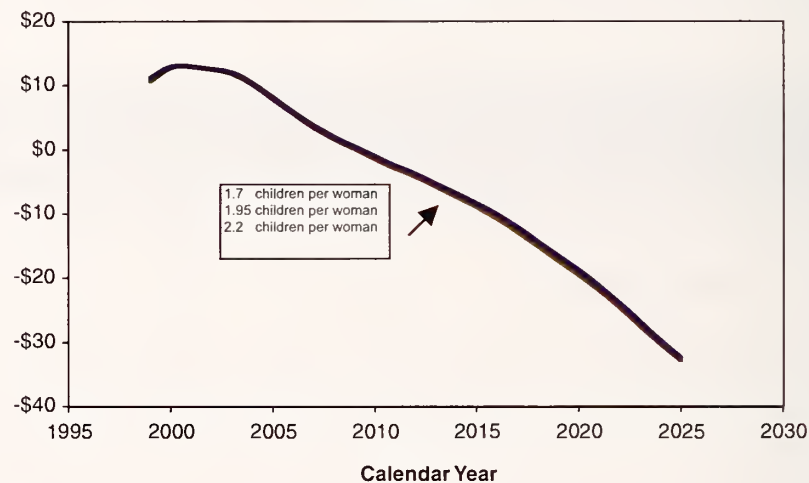
Source: HCFA/OAct



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

As charts 7 and 7A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows over the next 25 years. This result is because higher fertility in the first year only affects the labor force after roughly 20 years (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the changes are somewhat greater, as illustrated by the present values in table 3.

**Chart 7A—Present Value of HI Net Cashflow with  
Various Ultimate Fertility Rate Assumptions  
1999 - 2025**  
(In billions)



Source: HCFA/OAcl

## Net Immigration

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 655,000 persons, 900,000 persons, and 1,210,000 persons per year.

**Table 4  
Present Value of Estimated HI Income Less Expenditures  
under Various Net Immigration Assumptions**

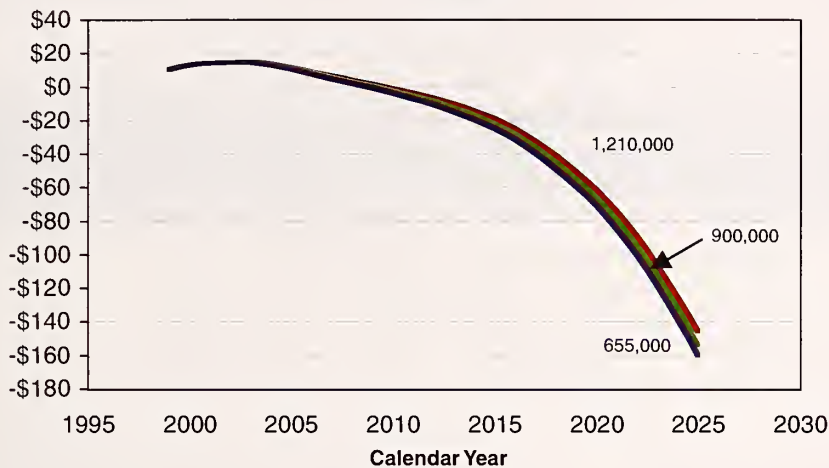
Ultimate net immigration	655,000	900,000	1,210,000
Income minus expenditures	-\$2,725	-\$2,700	-\$2,657

Table 4 demonstrates that if the ultimate net immigration assumption is decreased from 900,000 to 655,000 persons, the deficit of income over expenditures increases from \$2,700 billion to \$2,725 billion. On the other hand, if the ultimate net immigration assumption is increased from 900,000 to 1,210,000 persons, the deficit decreases to \$2,657 billion.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Charts 8 and 8A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 4.

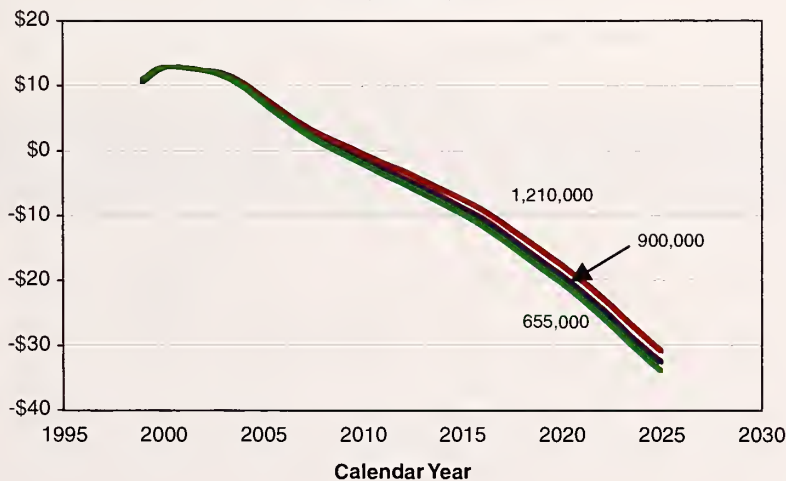
**Chart 8—HI Net Cashflow with Various  
Net Immigration Assumptions  
1999 - 2025**  
(In billions)



Source: HCFA/OAct

As charts 8 and 8A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among younger individuals, the number of covered workers is affected immediately, while the number of beneficiaries is affected much less quickly. Nonetheless, variations in net immigration result in fairly small differences in cashflow.

**Chart 8A—Present Value of HI Net Cashflow with  
Various Net Immigration Assumptions  
1999 - 2025**  
(In billions)



Source: HCFA/OAct

## Real-Wage Differential

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.0, and 1.5 percentage points. In each case, the CPI is assumed to be 3.3 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.8, 4.3, and 4.8 percent, respectively.

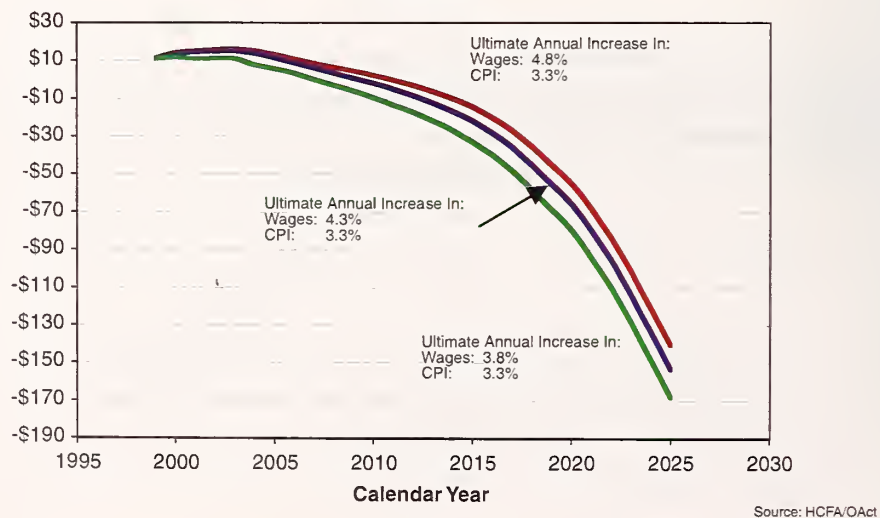
**Table 5**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Real-Wage Assumptions**

Ultimate percentage increase in wages - CPI	3.8 - 3.3	4.3 - 3.3	4.8 - 3.3
Ultimate percentage increase in real-wage differential	0.5	1.0	1.5
Income minus expenditures	-\$2,745	-\$2,700	-\$2,646

Table 5 demonstrates that if the ultimate real-wage differential assumption is decreased from 1.0 percentage point to 0.5 percentage point, the deficit of income over expenditures increases from \$2,700 billion to \$2,745 billion. On the other hand, if the ultimate real-wage differential assumption is increased from 1.0 percentage point to 1.5 percentage points, the deficit decreases to \$2,646 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 5.

**Chart 9—HI Net Cashflow with Various Real-Wage Assumptions**  
**1999 - 2025**  
(in billions)

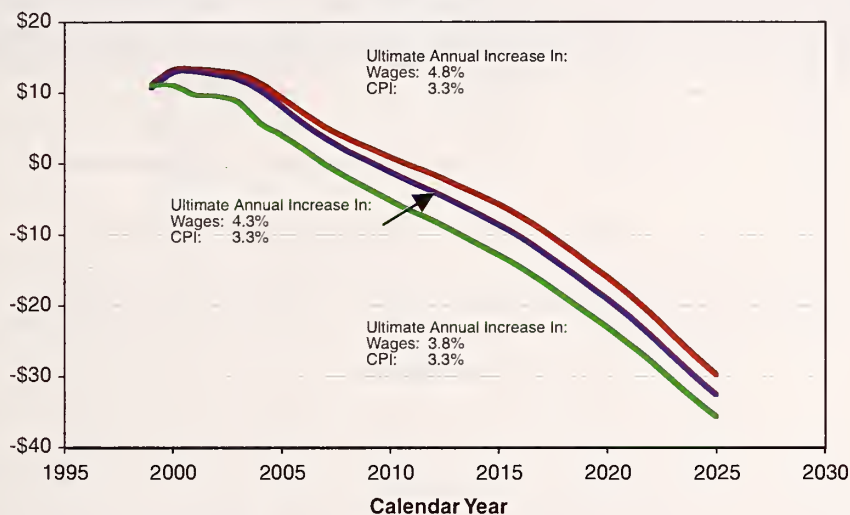




## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

As charts 9 and 9A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related.

**Chart 9A—Present Value of HI Net Cashflow with  
Various Real-Wage Assumptions  
1999 - 2025**  
(In billions)



Source: HCFA/OAct

## Consumer Price Index

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 2.3, 3.3, and 4.3 percent. In each case, the ultimate real-wage differential is assumed to be 1.0 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.3, 4.3, and 5.3 percent, respectively.

**Table 6  
Present Value of Estimated HI Income Less Expenditures  
under Various CPI-Increase Assumptions**

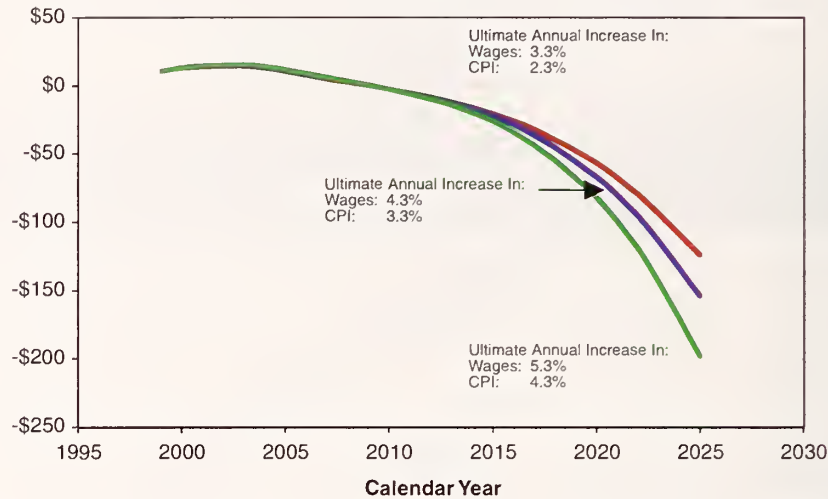
Ultimate percentage increase in wages - CPI	3.3 - 2.3	4.3 - 3.3	5.3 - 4.3
Income minus expenditures	-\$2,716	-\$2,700	-\$2,696

Table 6 demonstrates that if the ultimate CPI increase assumption is decreased from 3.3 percent to 2.3 percent, the deficit of income over expenditures increases from \$2,700 billion to \$2,716 billion. On the other hand, if the ultimate CPI increase assumption is increased from 3.3 percent to 4.3 percent, the deficit decreases to \$2,696 billion.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

Charts 10 and 10A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 6.

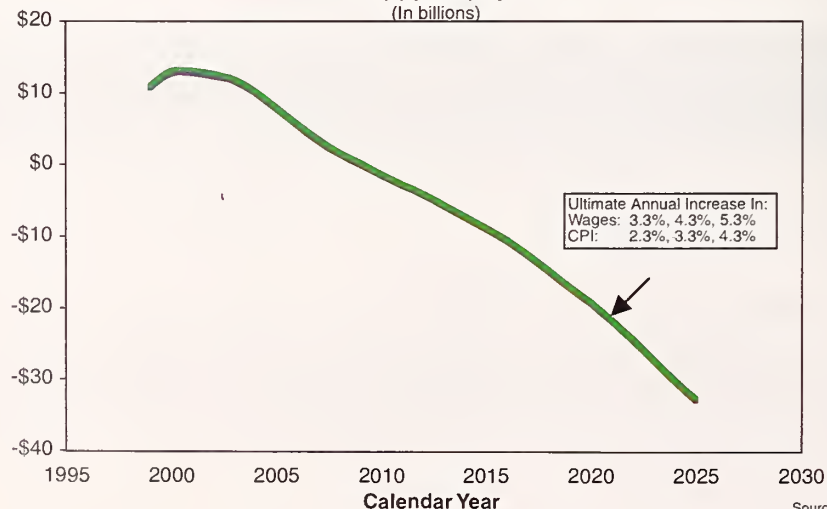
**Chart 10—HI Net Cashflow with Various  
CPI-Increase Assumptions  
1999 - 2025**  
(In billions)



Source: HCFA/OAct

As charts 10 and 10A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs equally. In nominal dollars, however, a given deficit “looks bigger” under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

**Chart 10A—Present Value of HI Net Cashflow  
with  
Various CPI-Increase Assumptions  
1999 - 2025**  
(In billions)



Source: HCFA/OAct

## Real-Interest Rate

Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 3.3 percent, resulting in ultimate annual yields of 5.5, 6.3, and 7.0 percent, respectively.

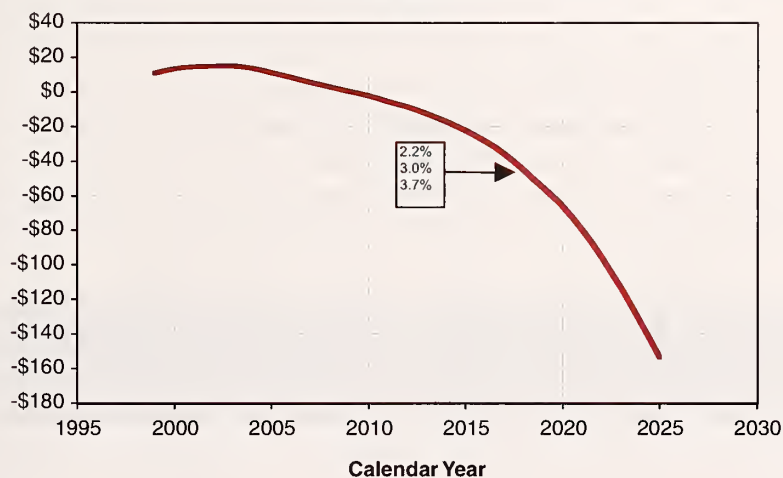
**Table 7**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Real-Interest Assumptions**

Ultimate real-interest rate	2.2 %	3.0 %	3.7 %
Income minus expenditures	-\$3,847	-\$2,700	-\$1,917

Table 7 demonstrates that if the ultimate real-interest rate percentage is decreased from 3.0 percent to 2.2 percent, the deficit of income over expenditures increases from \$2,700 billion to \$3,847 billion. On the other hand, if the ultimate real-interest rate assumption is increased from 3.0 percent to 3.7 percent, the deficit decreases to \$1,917 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 7.

**Chart 11—HI Net Cashflow with Various**  
**Real-Interest Rate Assumptions**  
**1999 - 2025**  
(In billions)



Source: HCFA/OAcl

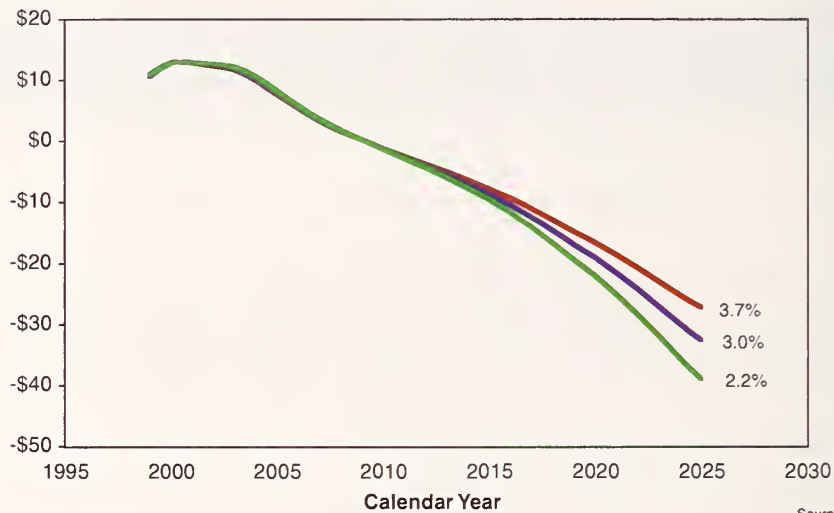
As shown in charts 11 and 11A, the present values of the net cashflow are more sensitive to the interest assumption than the net cashflow. This is not an indication of the actual role that interest plays in the financing of the HI program. In actuality, interest finances very little of the cost of the HI program because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2025. These



## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), and the overall net present value is smaller.

**Chart 11A—Present Value of HI Net Cashflow with Various Real-Interest Rate Assumptions 1999 - 2025**  
(In billions)



Source: HCFA/OAcl

## Health Care Cost Factors

Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

**Table 8**  
**Present Value of Estimated HI Income Less Expenditures**  
**under Various Health Care Cost Growth Rate Assumptions**

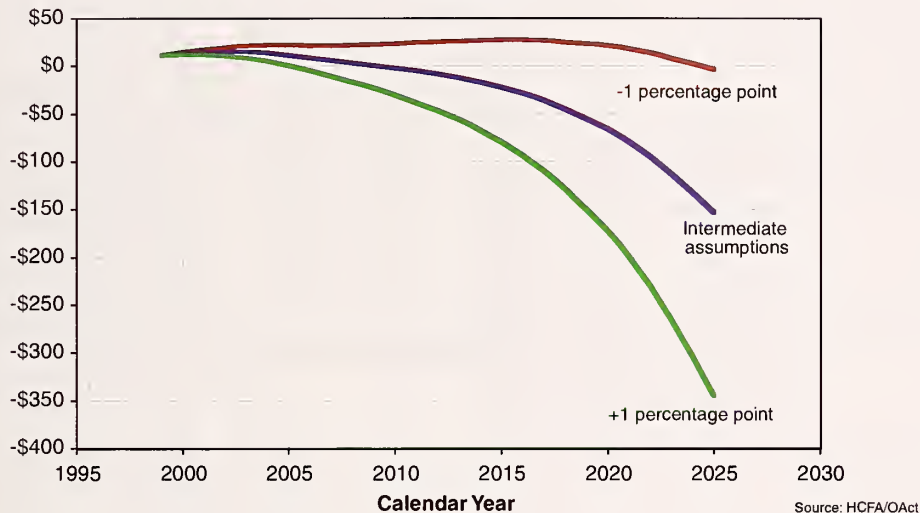
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+ 1 percentage point
Income minus expenditures	\$129	-\$2,700	-\$7,236

Table 8 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income over expenditures actually becomes a surplus of \$129 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially to \$7,236 billion.

## REQUIRED SUPPLEMENTARY STEWARDSHIP INFORMATION

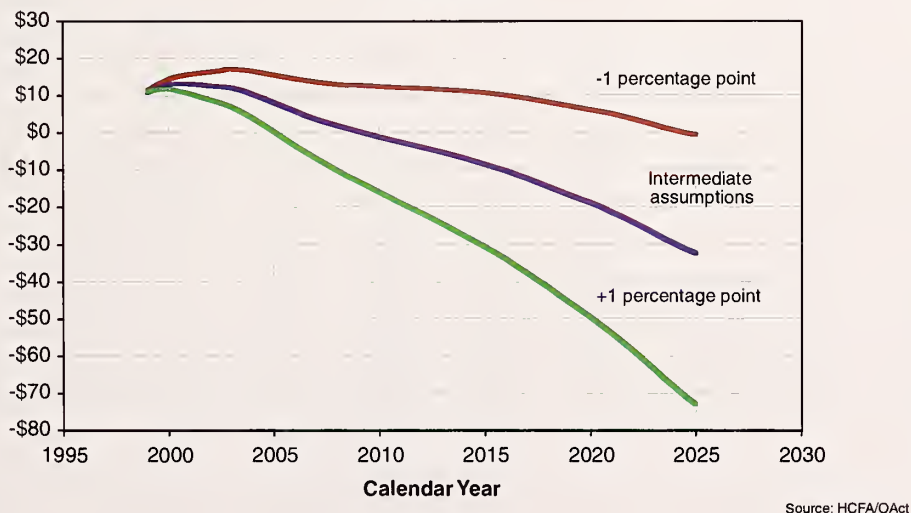
Charts 12 and 12A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 8.

**Chart 12—HI Net Cashflow with Various  
Health Care Cost Factor Assumptions  
1999 - 2025**  
(In billions)



This assumption has a dramatic impact on projected HI cashflow. The assumptions analyzed thus far have affected HI income and costs simultaneously. However, several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 12 and 12A indicate, the financial status of the HI program is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll.

**Chart 12A—Present Value of HI Net Cashflow with  
Various Health Care Cost Factors  
1999 - 2025**  
(In billions)



## **PROGRAM FINANCES AND SUSTAINABILITY**

### **HI**

The HI program is substantially out of financial balance in the long range. Under the Medicare Trustees' intermediate assumptions, income is projected to continue to moderately exceed expenditures for the next 17 years but to fall short by steadily increasing amounts in 2017 and later. These shortfalls can be met by redeeming trust fund assets, but only until 2025. The HI program could be brought into actuarial balance over the next 25 years with relatively minor changes, such as either reducing outlays or increasing income by 4 percent immediately (or some combination of the two) throughout this 25-year period.

The long-range outlook, however, remains unfavorable, in large part as a result of the impending retirement of the baby boom generation. Over the full 75-year projection period, substantially greater changes in income and/or outlays are needed to bring the program into actuarial balance.

The projections shown in this section indicate that without additional legislation, the fund would be exhausted in the future—initially producing payment delays, but very quickly leading to a curtailment of health care services to beneficiaries. In their 2000 annual report to Congress, the Medicare Board of Trustees urges the nation's policy makers to address the remaining financial imbalance facing the HI trust fund by taking "further effective and decisive action, building on the strong steps taken in recent reforms." They also state that "Consideration of further reforms should occur in the relatively near future."

### **SMI**

The financing established for the SMI program for calendar year 2000 is estimated to be sufficient to cover program expenditures for that year and to preserve an adequate contingency reserve in the SMI trust fund. Moreover, for all future years, trust fund income is projected to equal expenditures—but only because beneficiary premiums and government general revenue contributions are set to meet expected costs each year.

The SMI program's automatic financing provisions prevent crises such as those faced in recent years by the HI trust fund, where assets were projected to be exhausted in the near future. As a result, there has been substantially less attention directed toward the financial status of the SMI program than to the HI program—even though SMI expenditures have increased faster than HI expenditures in most years and are expected to continue to do so in the future.

SMI program costs have generally grown faster than the GDP, and this trend is expected to continue under present law. The projected increases are initially attributable in part to assumed continuing growth in the volume and intensity of services provided per beneficiary. Starting in 2010, the retirement of the post-World War II baby boom generation will also have a major influence on the growth in program costs. This growth in SMI expenditures relative to GDP is a matter of great concern. In their 2000 annual report to Congress, the Medicare Board of Trustees emphasizes the seriousness of these concerns and urges the nation's policy makers "to consider effective means of controlling SMI costs in the near term."



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**

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# **Supplementary Section**

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**HCF**



## SUPPLEMENTARY SECTION

### CONSOLIDATING BALANCE SHEET

**As of September 30, 2000**

(in millions)

	-MEDICARE- HI	SMI	HEALTH Medicaid	SCHIP	Other	Combined Total
<b>ASSETS</b>						
<b>Intragovernmental Assets:</b>						
Fund Balance with Treasury	\$(762)	\$3,976	\$5,694	\$10,951	\$232	\$20,091
Trust Fund (TF) Investments	171,736	45,830				217,566
Accounts Receivable	484					484
FICA Tax Adjustment	1,313					1,313
<b>Other Assets</b>						
Anticipated Congressional Appropriation			6,561			6,561
<b>Total Intragovernmental Assets</b>	<b>172,771</b>	<b>49,806</b>	<b>12,255</b>	<b>10,951</b>	<b>232</b>	<b>246,015</b>
Accounts Receivable, Net	2,560	1,153	79		1	3,793
Interest and Penalties Receivable, Net					85	85
Advances to Grantees		2				2
Cash and Other Monetary Assets	8	53				61
Property, Plant and Equipment, Net	6	11	1			18
<b>TOTAL ASSETS</b>	<b>\$175,345</b>	<b>\$51,025</b>	<b>\$12,335</b>	<b>\$10,951</b>	<b>\$318</b>	<b>\$249,974</b>

	-MEDICARE- HI	SMI	HEALTH Medicaid	SCHIP	Other	Combined Total
<b>LIABILITIES</b>						
<b>Intragovernmental Liabilities:</b>						
Accrued Payroll and Benefits	\$1	\$3				\$4
Other Liabilities	228	105	\$1		\$93	427
<b>Total Intragovernmental Liabilities</b>	<b>229</b>	<b>108</b>	<b>1</b>		<b>93</b>	<b>431</b>
Accounts Payable	10	21	2			33
Entitlement Benefits Due and Payable	12,689	11,496	12,331			36,516
Federal Employee and Veterans' Benefits	3	6	1			10
Accrued Payroll and Benefits	34	29	3			66
Other Liabilities	53	119			15	187
<b>TOTAL LIABILITIES</b>	<b>\$13,018</b>	<b>\$11,779</b>	<b>\$12,338</b>		<b>\$108</b>	<b>\$37,243</b>

<b>NET POSITION</b>						
Unexpended Appropriations	\$13	\$3,129		\$10,951	\$26	\$14,119
Cumulative Results of Operations	162,314	36,117	\$(3)		184	198,612
<b>TOTAL NET POSITION</b>	<b>\$162,327</b>	<b>\$39,246</b>	<b>\$(3)</b>	<b>\$10,951</b>	<b>\$210</b>	<b>\$212,731</b>
<b>TOTAL LIABILITIES &amp; NET POSITION</b>	<b>\$175,345</b>	<b>\$51,025</b>	<b>\$12,335</b>	<b>\$10,951</b>	<b>\$318</b>	<b>\$249,974</b>



## SUPPLEMENTARY SECTION

### CONSOLIDATING BALANCE SHEET

**As of September 30, 2000**

(in millions)

	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
<b>ASSETS</b>			
<b>Intragovernmental Assets:</b>			
Fund Balance with Treasury	\$20,091		\$20,091
Trust Fund (TF) Investments	217,566		217,566
Accounts Receivable	484		484
FICA Tax Adjustment	1,313		1,313
<b>Other Assets</b>			
Anticipated Congressional Appropriation	6,561		6,561
<b>Total Intragovernmental Assets</b>	246,015		246,015
Accounts Receivable, Net	3,793		3,793
Interest and Penalties Receivable, Net	85		85
Advances to Grantees	2		2
Cash and Other Monetary Assets	61		61
Property, Plant and Equipment, Net	18		18
<b>TOTAL ASSETS</b>	<b>\$249,974</b>		<b>\$249,974</b>
<b>LIABILITIES</b>			
<b>Intragovernmental Liabilities:</b>			
Accrued Payroll and Benefits	\$4		\$4
Other Liabilities	427		427
<b>Total Intragovernmental Liabilities</b>	431		431
Accounts Payable	33		33
Entitlement Benefits Due and Payable	36,516		36,516
Federal Employee and Veterans' Benefits	10		10
Accrued Payroll and Benefits	66		66
Other Liabilities	187		187
<b>TOTAL LIABILITIES</b>	<b>\$37,243</b>		<b>\$37,243</b>
<b>NET POSITION</b>			
Unexpended Appropriations	\$14,119		\$14,119
Cumulative Results of Operations	198,612		198,612
<b>TOTAL NET POSITION</b>	<b>\$212,731</b>		<b>\$212,731</b>
<b>TOTAL LIABILITIES &amp; NET POSITION</b>	<b>\$249,974</b>		<b>\$249,974</b>

## SUPPLEMENTARY SECTION

### CONSOLIDATING STATEMENT OF NET COST

**As of September 30, 2000**

(in millions)

	— MEDICARE —			— HEALTH —			Combined
	HI	SMI	Total	Medicaid	SCHIP	Other	Total
<b>NET PROGRAM/ACTIVITY COSTS</b>							
<b>GPRA Programs</b>							
Medicare							
<i>(Includes estimated improper payments of \$7.5-\$16.2 billion)</i>	\$127,945	\$69,096	\$197,041				\$197,041
Medicaid				\$118,705			118,705
SCHIP					\$1,273		1,273
<b>NET COST - GPRA PROGRAMS</b>	<b>127,945</b>	<b>69,096</b>	<b>197,041</b>	<b>118,705</b>	<b>1,273</b>		<b>317,019</b>
<b>Other Activities</b>							
CLIA						(18)	(18)
Other						5	5
<b>NET COST - OTHER ACTIVITIES</b>						<b>(13)</b>	<b>(13)</b>
<b>NET COST OF OPERATIONS</b>	<b>\$127,945</b>	<b>\$69,096</b>	<b>\$197,041</b>	<b>\$118,705</b>	<b>\$1,273</b>	<b>\$(13)</b>	<b>\$317,006</b>

### CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

**As of September 30, 2000**

(in millions)

	— MEDICARE —			— HEALTH —			Combined
	HI	SMI	Total	Medicaid	SCHIP	Other	Total
<b>NET COST OF OPERATIONS</b>	<b>\$127,945</b>	<b>\$69,096</b>	<b>\$197,041</b>	<b>\$118,705</b>	<b>\$1,273</b>	<b>\$(13)</b>	<b>\$317,006</b>
<b>Financing Sources</b>							
<i>(other than exchange revenues):</i>							
Appropriations Used	9,449	65,266	74,715	118,570	1,268	4	194,557
Taxes <i>(and other non-exchange revenue)</i>	152,794	3,458	156,252				156,252
Imputed Financing	7	15	22	1			23
Transfers-in							
Federal Matching Contributions		65,266	65,266				65,266
Non-Expenditure							
Transfers-Benefit Payments	128,400	87,520	215,920				215,920
Trust Fund Draws	630	1,157	1,787	130	5	61	1,983
Other	10,336	1	10,337				10,337
Transfers-out							
Non-Expenditure							
Transfers-Benefit Payments	(128,400)	(87,520)	(215,920)				(215,920)
Expenditure Transfers to							
Program Management	(724)	(1,259)	(1,983)				(1,983)
Payments to Health Care							
Trust Funds	(9,449)	(65,266)	(74,715)				(74,715)
Other	(497)	(521)	(1,018)				(1,018)
Other Revenues and							
Financing Sources							
Reclassification of Equity Accounts	(8)	46	38	(1)		(1)	36
<b>TOTAL FINANCING SOURCES</b>	<b>162,538</b>	<b>68,163</b>	<b>230,701</b>	<b>118,700</b>	<b>1,273</b>	<b>64</b>	<b>350,738</b>
<b>NET RESULTS OF OPERATIONS</b>	<b>34,593</b>	<b>(933)</b>	<b>33,660</b>	<b>(5)</b>		<b>77</b>	<b>33,732</b>
<b>NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS</b>	<b>34,593</b>	<b>(933)</b>	<b>33,660</b>	<b>(5)</b>		<b>77</b>	<b>33,732</b>
Increase (Decrease)							
in Unexpended Appropriations	(21)	3,129	3,108	(60)	2,991	(2)	6,037
<b>CHANGE IN NET POSITION</b>	<b>34,572</b>	<b>2,196</b>	<b>36,768</b>	<b>(65)</b>	<b>2,991</b>	<b>75</b>	<b>39,769</b>
Net Position-Beginning of Period	127,755	37,050	164,805	62	7,960	135	172,962
<b>NET POSITION-END OF PERIOD</b>	<b>\$162,327</b>	<b>\$39,246</b>	<b>\$201,573</b>	<b>\$(3)</b>	<b>\$10,951</b>	<b>\$210</b>	<b>\$212,731</b>

## SUPPLEMENTARY SECTION

### CONSOLIDATING STATEMENT OF NET COST

As of September 30, 2000

(in millions)

	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
<b>NET PROGRAM/ACTIVITY COSTS</b>			
<b>GPRA Programs</b>			
Medicare <i>(Includes estimated improper payments of \$7.5-\$16.2 billion)</i>	\$197,041		\$197,041
Medicaid	118,705		118,705
SCHIP	1,273		1,273
<b>NET COST - GPRA PROGRAMS</b>	<b>317,019</b>		<b>317,019</b>
<b>Other Activities</b>			
CLIA		(18)	(18)
Other		5	5
<b>NET COST - OTHER ACTIVITIES</b>		<b>(13)</b>	<b>(13)</b>
<b>NET COST OF OPERATIONS</b>		<b>\$317,006</b>	<b>\$317,006</b>

### CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

As of September 30, 2000

(in millions)

	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
<b>NET COST OF OPERATIONS</b>		<b>\$317,006</b>	<b>\$317,006</b>
<b>Financing Sources</b> <i>(other than exchange revenues):</i>			
Appropriations Used	194,557		194,557
Taxes <i>(and other non-exchange revenue)</i>	156,252		156,252
Imputed Financing	23		23
Transfers-in			
Federal Matching Contributions	65,266	(65,266)	
Non-Expenditure Transfers-Benefit Payments	215,920	(215,920)	
Trust Fund Draws	1,983	(1,983)	
Other	10,337	(9,449)	888
Transfers-out			
Non-Expenditure Transfers-Benefit Payments	(215,920)	215,920	
Expenditure Transfers to Program Management	(1,983)	1,983	
Payments to Health Care Trust Funds	(74,715)	74,715	
Other	(1,018)		(1,018)
Other Revenues and Financing Sources			
Reclassification of Equity Accounts	36		36
<b>TOTAL FINANCING SOURCES</b>	<b>350,738</b>		<b>350,738</b>
<b>NET RESULTS OF OPERATIONS</b>	<b>33,732</b>		<b>33,732</b>
<b>NET CHANGE IN CUMULATIVE RESULTS OF OPERATIONS</b>	<b>33,732</b>		<b>33,732</b>
Increase (Decrease) in Unexpended Appropriations	6,037		6,037
<b>CHANGE IN NET POSITION</b>	<b>39,769</b>		<b>39,769</b>
Net Position-Beginning of Period	172,962		172,962
<b>NET POSITION-END OF PERIOD</b>	<b>\$212,731</b>		<b>\$212,731</b>



## SUPPLEMENTARY SECTION

### COMBINING STATEMENT OF BUDGETARY RESOURCES

**As of September 30, 2000**

(in millions)

	HI	SMI	HCFAC	Payments to Trust Funds	Program Total
<b>Budgetary Resources:</b>					
Budget authority	\$158,592	\$89,239	\$864	\$78,152	\$3
Unobligated balances - beginning of period			26	34	235
Net Transfers prior year balance, actual					
Spending authority from offsetting collections			4		2,087
Adjustments	(29,226)	(114)		(34)	67
<b>TOTAL BUDGETARY RESOURCES</b>	<b>129,366</b>	<b>89,125</b>	<b>894</b>	<b>78,152</b>	<b>2,392</b>
<b>Status of Budgetary Resources:</b>					
Obligations incurred	129,366	89,125	864	75,010	2,195
Unobligated balances - available			30	3,142	77
Unobligated balances - not available					120
<b>TOTAL STATUS OF BUDGETARY RESOURCES</b>	<b>129,366</b>	<b>89,125</b>	<b>894</b>	<b>78,152</b>	<b>2,392</b>
<b>Outlays:</b>					
Obligations incurred	129,366	89,125	864	75,010	2,195
Less: spending authority from offsetting collections and adjustments			(5)		(2,179)
Obligated balance, net - beginning of period	465	34	149		(75)
Obligated balance transferred, net					
Less: obligated balance, net - end of period	(635)	(167)	(172)		(53)
<b>TOTAL OUTLAYS</b>	<b>\$129,196</b>	<b>\$88,992</b>	<b>\$836</b>	<b>\$75,010</b>	<b>\$(112)</b>

## SUPPLEMENTARY SECTION

### COMBINING STATEMENT OF BUDGETARY RESOURCES

**As of September 30, 2000**

(in millions)

	Medicaid	SCHIP	HMO Loan	Combined Totals
<b>Budgetary Resources:</b>				
Budget authority	\$118,981	\$4,259		\$450,090
Unobligated balances - beginning of period	1,117		\$11	1,423
Net Transfers prior year balance, actual			(2)	(2)
Spending authority from offsetting collections	50		1	2,142
Adjustments	1,771			(27,536)
<b>TOTAL BUDGETARY RESOURCES</b>	<b>121,919</b>	<b>4,259</b>	<b>10</b>	<b>426,117</b>
<b>Status of Budgetary Resources:</b>				
Obligations incurred	121,809	4,259		422,628
Unobligated balances - available	110			3,359
Unobligated balances - not available			10	130
<b>TOTAL STATUS OF BUDGETARY RESOURCES</b>	<b>121,919</b>	<b>4,259</b>	<b>10</b>	<b>426,117</b>
<b>Outlays:</b>				
Obligations incurred	121,809	4,259		422,628
Less: spending authority from offsetting collections and adjustments	(3,058)		(1)	(5,243)
Obligated balance, net - beginning of period	4,751	7,912		13,236
Obligated balance transferred, net				
Less: obligated balance, net - end of period	(5,581)	(10,951)		(17,559)
<b>TOTAL OUTLAYS</b>	<b>\$117,921</b>	<b>\$1,220</b>	<b>\$(1)</b>	<b>\$413,062</b>

## SUPPLEMENTARY SECTION

### HEALTH CARE FINANCING ADMINISTRATION GROSS COST AND EXCHANGE REVENUE As of September 30, 2000

(in millions)

#### NET PROGRAM/ACTIVITY COSTS

	INTRAGOVERNMENTAL		WITH THE PUBLIC		Consolidated
	Gross Cost	Less: Exchange Revenue	Gross Cost	Less: Exchange Revenue	Net Cost of Operations
<b>GPRA Programs</b>					
Medicare					
HI	\$141		\$129,200	\$1,396	\$127,945
SMI	106		89,505	20,515	69,096
Medicaid	9		118,696		118,705
SCHIP			1,273		1,273
<b>SUBTOTAL</b>	<b>256</b>		<b>338,674</b>	<b>21,911</b>	<b>317,019</b>
<b>Other Activities</b>					
CLIA	20		102	140	(18)
Other		3	8		5
<b>SUBTOTAL</b>	<b>20</b>	<b>3</b>	<b>110</b>	<b>140</b>	<b>(13)</b>
<b>PROGRAM/ACTIVITY TOTALS</b>	<b>\$276</b>	<b>\$3</b>	<b>\$338,784</b>	<b>\$22,051</b>	<b>\$317,006</b>



## SUPPLEMENTARY SECTION

### INTRAGOVERNMENTAL BALANCES

**As of September 30, 2000**

(in millions)

	*TFM Dept. Code	Fund Bal. with Treasury	Investments	Accounts Receivable	Other
<b>INTRAGOVERNMENTAL ASSETS</b>					
<b>Agency</b>					
Department of the Treasury	20	\$20,091	\$217,566	\$1,313	\$6,561
Department of Defense	17, 21			61	
	57, 97				
All Other Federal Agencies				423	
		<b>\$20,091</b>	<b>\$217,566</b>	<b>\$1,797</b>	<b>\$6,561</b>

	*TFM Dept. Code	Accounts Payable	Environmental & Disposal Costs	Accrued Payroll & Benefits	Other
<b>INTRAGOVERNMENTAL LIABILITIES</b>					
<b>Agency</b>					
Department of Labor	16			\$2	
Department of the Treasury	20				\$412
Office of Personnel Management	24			2	
General Services Administration	47				13
All Other Federal Agencies					2
				<b>\$4</b>	<b>\$427</b>

	*TFM Dept. Code	Exchange Revenue	Gross Cost	Non-exchange Revenue Transfers-in	Revenue Transfers-out
<b>INTRAGOVERNMENTAL REVENUES &amp; EXPENSES</b>					
<b>Agency</b>					
Department of Commerce	13		\$1		
Department of the Interior	14		1		
Department of Justice	15		76		
Department of Labor	16		1		
Department of the Treasury	20		1		
Department of Defense	17, 21	\$1	48	\$61	
	57, 97				
Office of Personnel Management	24		63		
Social Security Administration	28			2	\$(998)
General Services Administration	47		34		(7)
Department of Transportation	69		1	2	
Department of Health and Human Services	75	2	26	292,618	(292,628)
All Other Federal Agencies			24	823	(4)
		<b>\$3</b>	<b>\$276</b>	<b>\$293,506</b>	<b>\$(293,637)</b>

\* Treasury Financial Manual

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**



# **Audit Opinion and Management Response**

**HCFE**







## Memorandum

FEB 20 2001

Date

*Michael Mangano*

From

Michael F. Mangano  
Acting Inspector General

Subject

Report on the Financial Statement Audit of the Health Care Financing Administration  
for Fiscal Year 2000 (CIN: A-17-00-02001)

To

Michael McMullan  
Acting Principal Deputy Administrator  
Health Care Financing Administration

The attached final report presents the results of the audit of the Fiscal Year (FY) 2000 financial statements of the Health Care Financing Administration (HCFA). The firm Ernst & Young LLP (E&Y) undertook the audit in support of the Departmentwide financial statement audit by the Office of Inspector General (OIG) and in accordance with the Government Reform Act of 1994. The OIG exercised technical oversight and quality control over the audit.

The audit objectives were to determine whether (1) the HCFA principal financial statements as of September 30, 2000, were fairly presented in all material respects; (2) HCFA internal controls provided reasonable assurance that transactions were properly recorded and accounted for to permit the preparation of reliable financial statements; and (3) HCFA complied with laws and regulations that could have a direct and material effect on the financial statements.

In the auditor's opinion, the HCFA financial statements present fairly, in all material respects, the financial position of HCFA as of September 30, 2000, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the fiscal year then ended in conformity with generally accepted accounting principles.

The HCFA is to be commended for achieving this important milestone for both FY 1999 and FY 2000. While substantial progress has been made in providing reliable financial information, HCFA continues to be impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. As discussed in the auditor's report on internal controls, material weaknesses continue in financial analysis, regional and central office oversight, and Medicare electronic data processing (EDP) controls.

**Financial Analysis and Regional and Central Office Oversight (Partial Repeat Condition).** Overall, the Medicare contractors have made significant improvements in maintaining supporting records for Medicare activities and yearend balances. However, because the contractors lack a formal, integrated accounting system to accumulate and

report financial information, they use ad hoc, labor-intensive reports, which increases the risk of material misstatement or omission. In addition, Medicare contractor controls over accounts receivable continue to need improvement.

At the HCFA central office, procedures were implemented which resulted in adjustments to accounts receivable balances reported by the contractors. However, these procedures did not ensure that accounts receivable activity included on the contractor financial reports was properly supported by detailed transactions. In addition, the HCFA central office did not have formal procedures documenting financial statement and financial reporting analysis functions, and regional offices did not perform certain procedures to help ensure that financial information provided by the contractors was reliable, accurate, and complete.

**Medicare Electronic Data Processing Controls (Repeat Condition).** The HCFA relies on extensive EDP operations at both its central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2000, numerous and continuing weaknesses at the Medicare contractors, as well as certain application control weaknesses at the contractors' shared systems, were prevalent. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy files, (3) improper Medicare payments, or (4) disruption of critical operations.

The HCFA's comments on the draft of this report have been incorporated where appropriate. Officials in your office have concurred with the recommendations and are in the process of taking corrective action.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

To facilitate identification, please refer to Common Identification Number A-17-00-02001 in all correspondence relating to this report.

Attachment

cc:

Dennis Williams  
Acting Assistant Secretary for  
Management and Budget

George H. Strader  
Deputy Assistant Secretary, Finance

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REPORT ON THE  
FINANCIAL STATEMENT AUDIT OF  
THE HEALTH CARE FINANCING  
ADMINISTRATION  
FOR FISCAL YEAR 2000**



**FEBRUARY 2001  
A-17-00-02001**



## Report of Independent Auditors

To the Inspector General of the  
Department of Health and Human Services, and  
the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA), an operating division of the Department of Health and Human Services as of September 30, 2000, and the related consolidating statements of net costs and changes in net position and the combined statements of budgetary resources and financing for the fiscal year then ended. These financial statements are the responsibility of HCFA's management. Our responsibility is to express an opinion on these financial statements based on our audit. The Medicaid Program, a major HCFA administered program, had total assets of \$12.3 billion as of September 30, 2000, and total net costs of \$118.7 billion for the year then ended. The Medicaid Program financial information, which is included in the HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and comments herein as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audit for the year ended September 30, 2000, in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and, Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*. These standards and requirements require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, based upon our audit and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the HCFA at September 30, 2000, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the fiscal year then ended, in conformity with accounting principles generally accepted in the United States.

Our audit was conducted for the purpose of expressing an opinion on the financial statements referred to in the first paragraph. The information in the Overview of the HCFA and the Supplemental Information of the HCFA is not a required part of the financial statements, but are considered supplementary information required by OMB Bulletin 97-01, *Form and Content of Agency Financial Statements*, as amended. Such information has not been subjected to the auditing procedures applied in the audit of the financial statements, and accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated January 26, 2001, on our consideration of the HCFA's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations. These reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

*Ernst & Young LLP*

January 26, 2001

## Report of Independent Auditors on Internal Control

To the Inspector General of the  
Department of Health and Human Services, and  
the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA) as of September 30, 2000, and the related consolidating statements of net costs and changes in net position and the combined statements of budgetary resources, and financing for the fiscal year then ended, and have issued our report thereon dated January 26, 2001. The Medicaid Program, a major HCFA administered program, had total assets of \$12.3 billion as of September 30, 2000, and total net costs of \$118.7 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and the comments reflected herein, insofar as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and, Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

In planning and performing our audit, we considered HCFA's internal control over financial reporting by obtaining an understanding of the agency's internal control, determined whether this internal control had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 01-02. We did not test all internal control relevant to operating objectives as broadly defined by the Federal Managers Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.



The management of HCFA is responsible for establishing and maintaining internal control. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs on internal control policies and procedures. The objectives of internal control are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting principles generally accepted in the United States; and data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information. Because of inherent limitations in any internal control, errors, and irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of internal control to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment, could adversely affect the agency's ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. However, we noted certain matters discussed in the following paragraphs involving the internal control and its operation that we consider to be reportable conditions. The first two such matters—Financial Systems, Regional and Central Office Oversight and Medicare Electronic Data Processing (EDP) Controls—noted below we consider to be material weaknesses.

## MATERIAL WEAKNESSES

### Financial Systems, Regional and Central Office Oversight (Partial Repeat Condition)

#### *Background*

The OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. HCFA relies on a decentralized organization, complex systems and ad hoc reports to accumulate data for financial reporting due to the lack of an integrated financial accounting system at the contractor level. Although the HCFA Central Office maintains the financial accounting system, produces accounting policies and procedures, and prepares financial statements, HCFA's accounting structure is decentralized in that many day-to-day decisions, processing of transactions, and reconciliations between subsidiary files and supporting documentation are performed at the contractors. As a result, integrated financial systems, a sufficient number of properly trained personnel, and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect errors and irregularities in a timely manner.

#### *Significant Steps Taken But Further Enhancements Needed*

During fiscal year 2000, HCFA had taken significant steps to resolve its material weaknesses related to accounts receivable and financial analysis and oversight reported in the fiscal year 1999 financial statement audit report and to improve financial management over more than \$300 billion in Medicare activities. For example, HCFA

- Reorganized its financial management organization at Central Office, including the addition of nine accountants in its Division of Accounting and a Deputy Chief Financial Officer to provide a focal point for financial management efforts.
- Developed a Chief Financial Officer (CFO) Comprehensive Plan for Financial Management that highlights HCFA's key financial management activities, projects, and activities. It is composed of 10 goals and 25 initiatives in support of HCFA's strategic vision for financial management efforts.
- Performed Service Auditor SAS 70 reviews documenting and assessing internal controls at 25 Medicare contractor sites. These reviews include assessing progress in implementing corrective actions for prior audits.

- Performed reviews to assess the effectiveness of internal control processes and validity of accounts receivable at March 30, 2000 at 14 contractor locations that noted progress in resolving prior findings at larger contractors. Such contractors comprised approximately 68% coverage of total Medicare contractors' accounts receivable balances.
- Developed analytical procedures for its accounts receivable and account balance activity including the performance of trend analyses on a quarterly basis for all contractor and Central Office locations. Additionally, HCFA has established a formalized supervisory review process to ensure financial statement amounts appear reasonable and variances are properly explained.
- Performed National Team Reviews at three contractor locations where Central Office personnel assessed internal control.
- Improved internal controls related to fund balance with treasury, investment, and financial reporting to ensure timely identification of material misstatements. Enhancements include: formalized required supervisory approvals, fluctuation analyses of interim and financial statement balances including explanations of unusual variances, and standardized schedules.
- Required a Chief Financial Officer position for Medicare Operations at each contractor location.
- Developed and implemented processes to improve compliance with the Debt Collection Act. Improvements include training Regional personnel in the Debt Collection Act activities, implementing at the Regional Offices a process to prepare financial reports on a monthly basis, and the transfer of older outstanding debt to Treasury to pursue collection efforts. Through this process, HCFA has referred approximately \$2 billion resulting in collections of several million of its outstanding accounts receivable that previously was considered uncollectible.
- Developed draft procedures for Central Office financial reporting and analyses processes to be implemented during fiscal year 2001.

While significant progress was made, especially with enhanced internal control processes at the Central Office, significant financial management issues continue to impair HCFA's ability to accumulate, analyze, and distribute reliable financial information. Our review of the internal control at selected Medicare contractors disclosed numerous weaknesses in HCFA's ability to report accurate financial information. These weaknesses are primarily due to the absence of certain components of a fully integrated financial management system; that such absences include full accrual accounting, a double-entry general ledger system, proper cut-off procedures and adequate source documentation for Medicare Program activity. Currently, Medicare contractors do not utilize uniform accounting systems that record, classify, and summarize information for the preparation of financial statements.



### *Lack of Integrated Financial Management System*

OMB Circular A-127, *Financial Management Systems*, requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair HCFA's and the Medicare contractors' abilities to adequately support accounts receivable and other financial balances reported.

As reported in 1999, Medicare contractors' claims processing systems do not have general ledger capabilities and there are limited system interfaces currently available and in use to process and prepare data for the HCFA 750/751 reports. The HCFA 750 /751 reports prepared by the contractors are the culmination of the transactions and activity that have transpired from the beginning of the fiscal year. Contractors monitor and track accounts receivable activity using claims processing systems, personal computer based software, and ad-hoc spreadsheet applications to tabulate, summarize and prepare the information presented on the HCFA 750/751 reports.

Because the claim processing systems utilized by HCFA and the Medicare Contractors lack general ledger capabilities, preparing the HCFA 750/751 reports is a labor intensive exercise requiring significant manual input and reconciliations between various systems and ad-hoc spreadsheet applications. We found little uniformity among the supporting schedules utilized by contractors to prepare these reports. The failure of double entry systems coupled with increased use of ad-hoc supporting schedules are contributing factors that increase the risk that contractors may report inconsistent information or that information reported may be incomplete or contain errors.

Although HCFA has initiated steps in implementing an integrated general ledger system (HIGLAS) for the contractor, Regional Office, and Central Office location, HIGLAS is not expected to be fully operational until 2007.

### *Financial Analyses and Reporting—Medicare Contractors*

Overall, the Medicare contractors have made significant improvements in maintaining supporting records for Medicare activities and year-end balances. However, because the contractors lack a formal integrated accounting system to accumulate and report financial information, the contractors are using Ad-hoc reports, which are very labor intensive to develop and utilize which increases the risk of material misstatement or omission. Through our procedures, we found that independent verification controls were not established or were not consistently applied to provide reasonable assurance that amounts reported by contractors to HCFA were valid, accurately summarized and sufficiently

documented. Additionally, we noted that due to the volume of transactions processed by the contractors, there is insufficient time available to thoroughly review financial data prior to submission to the central office.

#### *Medicare Contractor Accounts Receivable*

For the year ended September 30, 2000, HCFA reported a net accounts receivable balance of approximately \$3.8 billion, comprised of gross outstanding accounts receivable of \$8.1 billion and an aggregate allowance for uncollectible accounts of \$4.3 billion. Medicare accounts receivable primarily represent funds owed by providers to HCFA due to overpayments (known as Non-Medicare Secondary Payer (Non-MSP), as well as funds due from other entities in instance that Medicare is the secondary payer (MSP) of claims. HCFA's contractors are responsible for reporting and collecting the majority of these receivables (over 87 percent of the total outstanding balance at year-end). During fiscal year 2000, Medicare contractors' reported \$12.1 billion in new accounts receivable, \$8.9 billion in collections, and \$3.2 billion in transfers and other adjustments to accounts receivable balances. HCFA's central and regional offices manage the remaining balance including, \$6.0 billion of new accounts receivable and \$5.6 billion in collections relating to fiscal year 2000.

Although central office improvements—specifically trend analyses implemented starting with the quarter ending June 30, 2000—identified the significant errors at the contractors at September 30, 2000, our review of accounts receivable at ten contractors indicated that controls at the Medicare Contractor level in aggregate continue to need improvement. Control weaknesses identified were consistent, although representing a smaller dollar impact, as compared to those reviews performed at September 30, 1999 and the review of Medicare Contractor Accounts Receivables at March 30, 2000 by outside consultants.

The Medicare Accounts Receivable review as of March 31, 2000 identified improvements, but continued to note significant weaknesses in the contractor's processing of both Non-MSP and MSP accounts receivable. The outside consultants reported that as of March 31, 2000, errors related to Non-MSP were approximated at an overall absolute overstatement of \$173 million. Of the \$173 million, \$47 million represented unsubstantiated amounts due to lack of supporting documentation, approximately \$2 million relating to transfer errors, and approximately \$124 million, including a \$50 million adjustment due to unfiled cost reports, representing clerical and other errors. Procedures related to MSP accounts receivable balances estimated misstatements at an absolute value of \$201 million. The majority of the misstatement was due to systematic issues with the system used to track MSP accounts receivable and a lack of supporting documentation. Further, the consultants

noted that many accounts were old and for small amounts that were not being pursued for collection. Based on this review and the results of prior audits, the central office took corrective actions to improve controls at the contractors.

Our review of accounts receivable activities at September 30, 2000, identified the following deficiencies:

- We noted differences at two locations totaling \$4.3 million and \$3.7 million, respectively, where the ending balances for accounts receivable reported to HCFA Central Office did not agree to the detailed listing of accounts receivable maintained at the contractor.
- At two locations, we noted overstatements of \$41 million and \$10 million, respectively, to the year-end accounts receivable balances due to the inclusion of unfiled cost report data.

Further, we noted certain issues with the calculation of the allowance for uncollectible accounts. The HCFA 751 report requires contractors to report an aging of accounts receivable. During fiscal year 1999, HCFA CO updated its procedures and provided the contractors a suggested method for calculating the allowance for uncollectible accounts. HCFA guidelines state that the allowance for doubtful accounts receivable should be based on a systematic method which considers historical loss experience (current procedures call for 5 years when that is available), recent economic events, current and forecast conditions and inherent risks. Consistent with prior findings, we noted the following:

- At one location, we noted that the calculation for the allowance for uncollectible accounts was not performed for accounts receivable totaling \$41 million.
- At two locations, we noted errors in the classification of the aging of accounts receivable where errors were identified in aging categories up to \$14 million and \$44 million, respectively.
- At one location, we noted that the calculation for the allowance for uncollectible accounts receivable did not take into account approximately \$50 million in settlement accounts receivable related to bankruptcies.

#### *Medicare Contractor Reconciliation of Funds Expended*

Finally, the reconciliation of “total funds expended” on the HCFA 1522, Monthly Contractor Financial Report is an important control that ensures all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, “total funds expended” is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified



by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. HCFA uses certain information from this report to prepare its financial statements.

Only 1 of the 10 contractors reviewed actually prepared the reconciliation on a monthly basis. Although the remaining 9 contractors reconciled monthly using monthly reports generated from internal systems, HCFA requires the monthly reconciliations to be performed using the actual paid claims tapes. For audit purposes, the reconciliation is critical because the auditors must be able to obtain a file of paid claims that will reconcile to the HCFA 1522 before selection of a statistically valid sample of claims is reviewed. Our analysis of the HCFA 1522 reports at 10 selected Medicare contractors identified the following internal control weaknesses.

- At one contractor we noted numerous material errors and omissions in the HCFA Form 1522 that were identified and corrected before the information was provided to HCFA. Over \$65 million in paid claims from the current month's HCFA Form 1522 were inadvertently included in the previous month's HCFA Form 1522 and a \$65 million plug amount was used to reconcile the difference in the current month.
- In addition, one contractor had to resubmit the HCFA Form 1522 because an unreported manual payment of \$6.3 million had not been posted to the contractors' financial records or the HCFA Form 1522.
- At one contractor there was a difference of about \$6 million for outstanding checks between what was reported on the form 1522 and what was included on the contractors' records.
- The reconciliation process at one contractor was delayed by more than two months because the contractor had great difficulty in providing paid claim tapes which supported the amounts shown on the HCFA 1522 report.

- We noted one contractor did not maintain a cash receipts or cash disbursement journal, did not prepare a trial balance to support amounts reported on the HCFA 750/751 reports, and utilized estimates to compute outstanding check amounts.
- At one contractor, we noted 50,000 beneficiaries in the universe of paid claims that were subsequently sampled that should not have been included on the paid claims tapes. The erroneous claims were zero paid claims from a prior quarter. After steps were taken to correct the paid claims tapes, the sample was redrawn.

### *Financial Analyses and Oversight—Regional and Central Office Oversight*

Pending improvements in HCFA's financial systems, financial analysis and Regional and Central Office oversight become critical to reduce the risk of material misstatement in the financial statements. However, as discussed below, HCFA's Central and Regional Office oversight of Medicare contractor operations and financial management controls have not provided reasonable assurance that material errors would be detected in a timely manner. One area that impacts the effectiveness of the oversight function is the complexity of HCFA's decentralized environment. In a decentralized accounting environment, the oversight function is impacted by the assignment of responsibilities among the various participants. For the oversight function to be effective, the division of responsibility should be documented with each participant agreeing and fully understanding the importance of its role in the process. The assignment of responsibilities of each participant should compliment the roles of the other participants.

#### *HCFA Regional Office*

Medicare contractors process claims submitted by providers, perform program safeguards activities, and prepare and submit periodic financial reports to HCFA that are used in the preparation of HCFA's financial statements. Oversight duties for contractor processes and systems are shared by the Central and Regional Offices, with the Regional Offices playing a critical oversight role in that they are the first level point of contact for the contractors. Medicare Regional Offices are responsible for:

- monitoring Medicare contractors to ensure that claims are processed in a timely manner.
- ensuring benefit payments are made as specified by law.
- assessing whether contractors have adequate controls in place to prepare financial reports and to determine that the reports are valid, accurate, and complete.

- performing assessments to ensure corrective actions are taken to resolve prior findings.
- monitoring the status of transfers of receivables between contractors and the Regional Offices and between the Regional Offices and Central Office.
- monitoring contractors' compliance with systems security requirements through the performance of on-site reviews.

During fiscal year 2000, we visited two regional offices to assess the Regional Office oversight function and found consistently that certain procedures were not being performed to help ensure financial data provided by Medicare contractors is reliable, accurate, and complete. We noted the following:

- On a quarterly basis, contractors are required to submit financial reports to the regional office. These reports are used to collect the necessary information from the contractors for preparation of the HCFA annual financial statements. Although the regional office has the responsibility to ensure that the financial data reported on its financial statements is complete, accurate, valid, and fairly represents the financial position of HCFA, quarterly monitoring is limited to the performance of trend analyses and a cursory review to ensure that there are no unusual items. Additionally, because there is a lack of operating procedures, the follow-up on significant or unusual variances detected by the Trend Analysis are not consistent between contractors. During our review of accounts receivable as of March 31, 2000, numerous cases were identified whereby further follow-up or review of detailed information to support the reports would have identified and resolved issues on a more timely basis. For example, our audit identified errors at four contractor locations aggregating approximately \$118 million related to the provider benefit payable amounts reported and at another location we noted an understatement of an accrual for approximately \$70 million due to an error in the spreadsheet used to develop the accrual.
- The regional office performed annual on-site reviews at the contractor locations. Although the regional office followed-up on findings noted in the reviews it performed, no follow-up procedures were performed to ensure corrective actions on findings noted in the reviews performed by central office or outside consultants were completed by the contractors. Reliance was placed on the work of the consultants without a clear understanding at the regional office of what the responsibilities of the consultants were and the scope of the reviews performed.
- Although Contractors are required to maintain appropriate controls to safeguard Medicare records, operations, and data against disaster, disruption, unauthorized disclosure, theft, and fraud, it is the regional offices' responsibility to review contractors' internal controls over their automated systems and systems security. During fiscal year 2000, no system security reviews were performed. These



reviews include: 1) Entitywide Security Program Planning and Management, 2) Access Control, 3) System Software, 4) Segregation of Duties, 5) Service Continuity, 6) Application Software Development and Change Control, 7) Application System Authorization Controls, 8) Application System Completeness Controls, 9) Application System Accuracy Controls, and 10) Network.

- Change Management Plans are prioritized changes, normally edits to the systems, mandated by the HCFA central office to be completed by contractors on a quarterly basis. The regional office performed on-site reviews to ensure that change requests were implemented timely and properly. However, we noted that the regional office had not consistently followed-up with contractors who had not implemented changes properly or timely.

The U.S. General Accounting Office's *Standards for Internal Control in the Federal Government*, indicates that internal control monitoring should assess the quality of performance over time and ensure that findings of audits and other reviews are promptly resolved. Without appropriate monitoring and oversight of contractor operations, deficiencies in internal control may allow material misstatements to occur without being identified in a timely manner.

#### *HCFA Central Office*

Although significant improvements were noted in the accumulation and analyses of financial information in preparation of financial reporting, HCFA Central Office should continue to enhance its periodic analyses of information included in its financial statements. During fiscal year 2000, HCFA incorporated quarterly fluctuation analyses of accounts receivable by contractor into its procedures which resulted in adjustments to reported balances from the contractors and explanations for unusual variances. However, for financial reporting purposes, these procedures did not ensure that activity related to accounts receivable included on the 751 or amounts included in these fluctuations were properly supported by detailed transactions. Additionally, during fiscal year 2000, HCFA Central Office did not have formalized procedures documenting the financial statement and financial reporting analyses functions. The U.S. General Accounting Office's *Standards for Internal Control in the Federal Government* requires that internal control and all transactions need to be clearly documented in properly maintained management directives, administrative policies, or operating manuals. HCFA indicated that they had hired an outside consultant to prepare the formalized procedures; however, the project had not been completed at year-end.

*Recommendation*

We recommend that HCFA continue to reengineer its processes to improve its monitoring, analysis, and tracking. Specifically, we recommend that the following procedures be implemented:

- Establish an integrated financial management system for use by Medicare contractors, and HCFA's Central and Regional Offices to promote consistency and reliability in recording and reporting financial information, including accounts receivable and claim activity. Additionally, HCFA should continue its efforts to promote uniformity and integration of Medicare contractors' systems.
- Establish a task force to determine if current divisions of responsibility between the HCFA Central and Regional Offices, and the Medicare contractors are adequate to ensure financial information generated is complete, valid and properly valued and that corrective actions to prior findings are monitored. Additionally, the task force should assess whether the responsibility division is properly documented and that all organizations are in agreement and fully understand the importance of their role in the oversight function.
- Continue to develop procedures to provide a mechanism for HCFA Central and Regional Offices to monitor contractors' activities and enforce compliance with HCFA financial management procedures. This may include obtaining detailed subsidiary ledgers from contractors to the HCFA Regional and Central Offices, reviewing subsidiary ledgers for reasonableness, obtaining query access to financial systems to identify and investigate unusual items, and reviewing reconciliations prepared by the contractors consistently on a periodic basis. Additionally, HCFA should continue to refine its high level exception driven analysis and develop an archiving mechanism so that historical information is available for future trending.
- Continue to develop, implement, and monitor formalized policies and procedures in the preparation and analyses of financial reports. Additionally, refinement of policies and procedures is still needed to ensure that procedures are properly and consistently performed at the contractors and the Regional Offices.
- Provide additional training for financial personnel at the HCFA Central Office, the Regional Offices, and for the Medicare contractors to ensure that personnel understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.

- Develop appropriate input/output controls for routinely reviewing and documenting the HCFA reports received from Medicare contractors in order to timely identify unusual items and inconsistencies and to emphasize HCFA's reliance on these reports. With respect to output controls, we suggest that at a minimum, HCFA obtain detailed accounts receivable information by major type and contractor, arrayed by provider for the largest such accounts, and implement a monthly review at Regional and Central Offices.
- Ensure that all Medicare contractors develop and implement control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with contractors' supporting documentation, and periodically review contractors' control procedures over reconciliations, including the Medicare contractors' reconciliation of total funds expended, to ensure that required accounting reports, subsidiary ledgers, and adequate documentation are available on a timely basis to support the financial statement reporting requirements.
- Develop procedures to ensure an audit trail exists and approval of entries and assumptions are made for transactions at the Medicare contractors and HCFA Central and Regional Offices.

### **Medicare Electronic Data Processing (EDP) Controls (Repeat Condition)**

#### *Background and Scope of Review*

To effectively and efficiently control and administer the Medicare program and process and account for more than \$200 billion in federal Medicare expenditures in fiscal year (FY) 2000, HCFA continued to rely on significant data processing operations at both HCFA's Central Office and various contractors to process Medicare claims and maintain eligibility systems. HCFA's Central Office data center maintains administrative information such as Medicare enrollment, eligibility, and paid claims history information. The HCFA Central Office also processes all payments for Medicare managed care.

For consistency in the payment of Medicare for fee-for service claims, Medicare contractors use one of several "shared" systems. As a component of processing fee-for-service claims the "shared" systems interface with the Common Working File (CWF) to obtain authorization to pay submitted claims. The CWF is a distributed database system operated throughout the United States by seven Medicare Contractors, referred to CWF Hosts. The CWF is used to coordinate Medicare Part A and Part B benefits and approve claims for payment. The "shared" and CWF systems are designed and maintained by certain contractors referred to as systems maintainers.



Our review of the EDP internal control was limited to general data processing and application controls and did not include management or operational controls. General data processing controls, also referred to as “general controls,” are critical to ensuring the integrity, confidentiality, and availability of HCFA’s Medicare data that is processed by HCFA’s Central Office and contractors. General control objectives are defined for six categories: entity-wide security management program, access control, application development and program change controls, segregation of duties, operating systems software, and service continuity. The EDP general controls impact the integrity of all applications that are operated within a single data processing facility.

#### *Overview of Results of FY2000 EDP Review*

In the course of the FY 2000 EDP general controls reviews and the follow-up reviews from prior years, we found numerous and continuing weaknesses at the HCFA Central Office and the Medicare contractors, as well as certain application control weaknesses at the contractors’ shared systems. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in the Medicare contractors’ entity-wide security structure do not ensure that EDP controls are adequate and operating effectively. Overall, one continuing weakness remains in the EDP systems environment that has been identified as material.

In FY 2000, EDP control weaknesses were identified at nine Medicare contractors for which full-scope reviews were performed and of which three were subject to application review procedures. For these reviews, specific reportable conditions were identified in entity-wide security programs, access controls, application development and program change controls, segregation of duties, operating systems software controls and service continuity. Follow-up review procedures were performed during FY 2000 for five Medicare contractors and maintainers and the HCFA Central Office for which full-scope general, application, and maintainer reviews had been performed during FY 1999. Our follow-up reviews in FY 2000 of full-scope reviews performed in FY 1999 indicated that progress has been made to appropriately resolve many of the prior year findings.

Because certain reconciliation and report processes within HCFA are still evolving and require further improvement as noted in this report on internal control, the general and application controls are critically important to HCFA to ensure the integrity, confidentiality, and availability of sensitive Medicare data.

### *Medicare Contractors*

We completed general EDP control reviews at nine Medicare data processing facilities that support the Medicare contractors selected for the FY 2000 Chief Financial Officer (CFO) audit. In addition, application controls of the Fiscal Intermediary Shared System (FISS), the Multi-Carrier system (MCS), and the CWF were assessed at three separate contractors.

We identified opportunities for enhancing data processing controls at each of the nine Medicare contractors we reviewed. Specifically, we found that entity-wide security procedures, access controls, segregation of duties, operating systems software controls, and service continuity procedures needed to be enhanced at the nine contractors.

We found that the material weakness noted in the previous fiscal years related to the source code of the FISS system remains unchanged. This prior year material weakness remains open and has been expanded to include the CWF system, since the design of the CWF software provides for programmer update access to CWF data files to meet operational needs. We previously reported that Medicare data centers had access to the source code of FISS and are able to implement local changes to FISS programs. Such access may be abused resulting in unauthorized programs that are implemented and processed at fiscal intermediaries and carrier data centers. While HCFA requires contractors to restrict local changes to emergency situations, such local changes are often not subjected to the same controls that exist in the standard change control process.

### *HCFA Central Office Computer Facility*

Opportunities to enhance system controls persist at Central Office. For the FY 2000 Central Office follow-up review, we updated the status of prior year findings in the six general control areas described above. We determined that HCFA's Central Office has continued the implementation of enhanced control procedures, specifically in access controls and application development and program change controls but these efforts were incomplete as of the end of FY2000.

Significant control enhancements being implemented but not completed include:

- Issuance of task orders to various contractors to address issues related to risk assessment, security policies and procedures, independent verification and validation of entity-wide security plans and related procedures for significant systems.

- Migration to enterprise-wide program change management software, with full implementation planned for FY 2001.

HCFA should continue its focus on implementing appropriate corrective action plans in resolving all findings to improve the controls over integrity, confidentiality, and availability of Medicare data processed at the Central Office.

#### *Recommendation*

HCFA continues to rely heavily upon automated systems processed by the Medicare contractors for the consistent administration of virtually all aspects of the program. Accordingly, based on the significance of the source code weaknesses for the FISS and CWF Medicare contractors identified as a result of the FY 2000 review, the needed improvements for these systems are considered to be a material weakness. Detailed findings and recommendations for each full-scope review and follow-up review have been communicated to OIG and HCFA management.

#### Medicare Contractors and System Maintainers

HCFA management should, in conjunction with the Medicare contractors and system maintainers that support the overall development, maintenance, and processing of the Medicare system, continue to develop, implement, and monitor cost-effective controls to include:

- Consistent adherence to the OMB Circular A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data.
- Consistent and effective physical and logical access procedures, including administration and monitoring of access by Medicare contractor personnel in the course of their job responsibilities.
- Consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data. Appropriately controlled operating systems software products are fundamental to the integrity of processing of Medicare data.
- Attention to appropriate segregation of duties to ensure accountability and responsibility for access to Medicare applications and data are appropriately assigned.



- Updated and appropriately documented service continuity procedures to recover Medicare processing in the event of a system outage.

#### *Central Office*

HCFA management should continue to implement control improvements for the Central Office to include:

- Entity wide security management programs for all significant production applications and related users.
- Adequate, monitored, and enforceable general computer access controls to restrict sensitive data and other resources from unauthorized usage, modification, or destruction.
- Implementation of entity-wide consistent change control procedures for all significant production applications and systems software programs.
- Improved segregation of duties to include appropriate assignment of responsibilities.

### **REPORTABLE CONDITIONS**

#### **Medicare Entitlement Benefits Due and Payable (Repeat Condition)**

Medicare entitlement benefits due and payable totaled approximately \$24.2 billion at September 30, 2000. These liabilities represent the cost of services provided to Medicare beneficiaries but not paid at the end of the fiscal year. Significant strides were made by HCFA in analyzing the data produced and critically assessing results obtained, including implementing more formalized approaches to finalizing the estimate and documenting conclusions. However, current procedures may not be adequate to detect errors in data used in future projections. Specifically, we noted the following:

- Although HCFA had established informal procedures for validating and reviewing source data and estimates used in the preparation of the overall entitlement benefits due and payable estimate, additional enhancements are necessary to ensure reliability of the estimates.

- Testing of new system conversions did not identify (1) eliminated system processes needed for the estimation of the entitlement benefits due and payable and (2) incorrect indicator postings between the physician code and “other” category on a timely basis.
- Differences were noted between claims on the payment floor, outstanding checks, and periodic interim payment amounts reported by the contractor to HCFA and supporting documentation maintained at the contractors.
- STAR data, which are HCFA’s primary source for cost settlement information, are inconsistent with cost settlement information that recorded on the HCFA 1522 reports prepared by the contractors. Consequently, STAR data are adjusted to reconcile to balances included on the HCFA 1522 that is considered by HCFA to be more reliable.

#### *Recommendation*

We recommend that:

- Formalized policies and procedures should be strengthened to ensure sources of data are documented, amounts extracted are complete and accurate, processes which ensure that input to the incurred but not reported claim estimation model agrees with data in the general ledger, HCFA financial statements, and the changes in systems be made a standard protocol and analyses take place within the Office of Financial Management and Actuarial Office to explain unusual fluctuations in input data and results.
- Guidance should be provided to contractors to emphasize the need for accurate reporting of requested data. Further, procedures should be enhanced to validate contractor provided data, including requesting copies of report runs on a test basis as appropriate, and critically assess the appropriateness of the estimates provided and document management’s conclusion.
- HCFA assess the feasibility of modifying STAR data to accurately reflect cost settlement activities, adding necessary information on the date that a cost settlement is finalized, and when it is paid.

#### **Medicaid Claims Estimated Improper Payments (Repeat Condition)**

No methodology currently exists for estimating the range of improper Medicaid payments on a national level. The Office of Inspector General (OIG) has been reviewing a statistically valid sample of Medicare claims for the last several years and has determined an estimated range of improper payments out of the total fee for service payments processed by HCFA. The majority of the errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, noncovered or unallowable service, and incorrect coding. The results of this sampling provide HCFA with useful information in helping to reduce the overall Medicare improper payments. With no similar methodology

in place for the Medicaid Program, HCFA is unable to draw any conclusions at a national level on improper Medicaid payments. Since Medicaid is a grant program, any sampling would need to be done in conjunction with the states.

### *Recommendation*

We recommended in our prior report that HCFA work with the states to develop procedures for the implementation of a methodology to determine the range of improper payments in the Medicaid Program.

HCFA anticipates receiving funding of approximately \$2.4 million in fiscal 2001 toward this project. A project coordinator has been hired whose initial tasks will be to (1) post positions for additional staff, (2) prepare and mail to all the states a request for participation in a pilot project, and (3) prepare a Request for Proposal for outside assistance.

We continue to recommend that the workgroup be staffed as soon as possible and that work begin on development of a methodology that can be implemented in all the states on a consistent basis.

\* \* \* \* \*

In addition, we considered HCFA's internal control over Required Supplementary Stewardship Information by obtaining an understanding of the agency's internal control determined whether these internal controls had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on these internal controls. Our procedures with respect to trust fund projections consisted of comparing amounts reflected in the Required Supplementary Stewardship Information to Trustee reports and spreadsheets prepared by the Office of the Actuary and did not include re-performance of actuarial computations or tests of underlying computations or related controls, if any. Accordingly, we do not provide an opinion on such controls.

In addition, with respect to internal control related to performance measures reported in the Management Discussion and Analysis (MD&A), we obtained an understanding of the design of internal control relating to the existence and completeness assertions and determined whether they have been placed in operation, as required by OMB Bulletin 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.



We noted other matters involving internal control over financial reporting, which we have reported to Management in a separate letter dated January 26, 2001.

This report is intended solely for the information and use of the management of HCFA and the Department of Health and Human Services, OMB, and the Congress; and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst & Young LLP*

January 26, 2001

## Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the  
Department of Health and Human Services, and  
the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA) as of and for the year ended September 30, 2000, and the related consolidating statements of net costs and changes in net position, and combined statements of budgetary resources and financing for the year then ended, and have issued our report thereon dated January 26, 2001. The Medicaid Program, a major HCFA administered program, had total assets of \$12.3 billion as of September 30, 2000, and total net costs of \$118.7 billion for the year then ended. The Medicaid Program financial information, which is included in the HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and comments herein as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audit in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and, Office of Management and Budget (OMB) Bulletin 01-02, *Audit Requirements for Federal Financial Statements*.

The management of the HCFA is responsible for complying with laws and regulations applicable to the HCFA. As part of obtaining reasonable assurance about whether the HCFA's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 01-02, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to the HCFA. We caution that noncompliance may occur and not be detected by the tests performed and that such testing may not be sufficient for other purposes.

The results of our tests of compliance disclosed no instances of noncompliance with other laws and regulations discussed in the preceding paragraph exclusive of FFMIA that are required to be reported under *Government Auditing Standards* and OMB Bulletin 01-02.

Under FFMIA, we are required to report whether the HCFA's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements.

The results of our tests disclosed instances in which the HCFA's financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instances of noncompliance.

- HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the existing financial reporting system does not conform to the requirements currently specified by the Joint Financial Management Improvement Program.
- Weaknesses identified in HCFA's Central Office and Medicare financial management systems' access and application controls are significant departures from requirements specified in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

As reported by HCFA in Footnote 11 to the financial statements referenced above, certain claims submitted by providers do not comply with Medicare laws and regulations.

The Report of Independent Auditors on Internal Control and our separate management letter includes information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from the HCFA's management responsible for addressing the noncompliance, including management's proposed action plan, are provided as an attachment to this report.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.



This report is intended solely for the information and use of the management of the HCFA and the Department of Health and Human Services, OMB and Congress; and is not intended to be and should not be used by anyone other than these specified parties.

*Ernst + Young LLP*

January 26, 2001



7500 SECURITY BOULEVARD  
BALTIMORE MD 21244-1850

Ernst & Young L.L.P.  
1225 Connecticut Avenue, N.W.  
Washington, D. C. 20036

Dear Sir:

This letter is in response to your audit report on the Health Care Financing Administration's (HCFA) fiscal year (FY) 2000 financial statements. Your report identifies two material weaknesses: 1) Financial Systems, and Central and Regional Office Oversight; and 2) Medicare Electronic Data Processing (EDP) controls. Each of these weaknesses is repeated from the FY 1999 audit of HCFA's financial statements.

HCFA generally concurs with the findings and descriptions of weaknesses. As noted in your report, HCFA has made many improvements in the area of financial management during FY 2000. Specifically, we developed a Chief Financial Officer (CFO) Comprehensive plan that highlights HCFA's key financial management activities, projects, and activities. We also developed analytical procedures for accounts receivable and account balance activity, including the performance of quarterly trending analysis on financial data reported by all Medicare contractors and central office locations. Additionally, HCFA has established a formalized supervisory review process to ensure financial statement amounts appear reasonable and variances are properly explained. We also continue to provide training to personnel at Medicare contractor sites, the regional offices, and central office regarding the accumulation and verification of financial information.

HCFA's lack of an integrated general ledger accounting system that captures financial data at the contractor level continues to be a factor contributing to these repeated weaknesses. While we have developed and are implementing short term corrective actions to address these noted weaknesses, we anticipate that HCFA will be able to fully resolve them once our integrated general ledger system at the contractors is fully operational.

As we continue to make significant progress in our efforts to address these weaknesses, we remain committed to our goal of providing reliable financial information regarding the operation of HCFA's programs. We will continue to track our progress and report it to the Department on a regular basis.

I would also like to thank your office for working so diligently with my staff to address the financial issues that arose during the course of the audit.

Sincerely,

A. Michelle Snyder  
Chief Financial Officer





**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**

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# **HCFA Other Reports**





# FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

## **Material Weakness 1: Financial Reporting to Account for Medicare Accounts Receivable and Other Financial Information**

HCFA has limited assurance whether account balances are accurate or supported by the appropriate documentation, and is not well positioned to identify emerging trends in accounts receivable activities and other financial information that may require additional attention. Additionally, HCFA cannot readily isolate or identify activities in accounts receivable that could have a material impact on the financial statements.

HCFA continues to provide instructions/guidance to the Medicare contractors by clarifying policy on the identification of an account receivable, including, periodic interim payments, under tolerance, claims accounts receivable, voluntary refunds, consent settlements, and incomplete accounts receivable. As HCFA progresses toward its long-term goal of developing an integrated general ledger accounting system, we continue to provide training to the contractors to promote a uniform method for reporting and accounting for accounts receivable and related financial data. HCFA will continue to use consultants to evaluate the validity of the accounts receivable.

All short-term corrective actions for FY 2000 have been completed. We acquired consultant services to ensure that the accounts receivable balances for FY 2000 were valid and properly valued and to review the implementation of prior year corrective action plans.

In addition, we hired a CPA firm to develop trend analysis procedures for accounts receivable, revenues, and expenditures to track fluctuations within balances. HCFA is also developing the HCFA Integrated General Ledger Accounting System (HIGLAS) that will incorporate Medicare contractors' financial data.

## **Material Weakness 2: Medicare Contractors Systems Application Controls**

Two weaknesses are outstanding in the application controls for Medicare contractors.

- One fiscal intermediary had developed and implemented an override library that gave locally changed programs higher execution priorities over the source code for the standard Fiscal Intermediary Shared System (FISS) programs provided by the FISS maintainer. This issue has been expanded to include the Common Working File (CWF) system, since the design of the CWF software provides for programmer update access to CWF data files to meet operational needs.



## HCFA OTHER REPORTS

- At another fiscal intermediary, the programmers made local changes to the FISS programs outside of the Program Assistance Request (PAR) process. Programming changes performed locally are not subjected to the same documentation, authorization, testing, quality assurance, and other requirements present in the standard PAR process.

HCFA is addressing the override and changes to the FISS identified above. The fiscal intermediary that made the changes to the FISS code took actions to formally document the changes. HCFA is developing compensating controls and oversight to ensure that inappropriate changes are not made to the source code. HCFA issued changes to CWF that corrects the access issue identified above in January 2001.

A finding identified in the FY 1999 FMFIA report pertaining to the Medicare Contractor System (MCS) has been resolved. The MCS is a carrier shared system application that contains numerous edits and audits. The MCS findings that related to the exact duplicate edits was resolved during FY 1999 and is no longer considered a material control weakness.

HCFA is revising its information systems security requirements for Medicare contractors. The revision will include *HCFA Core Information Security Requirements*. The core requirements will be based on a synthesis of OMB Circular A-130, *General Accounting Office Federal Information System Controls Audit Manual*, Internal Revenue Service Publication 1075, Health Insurance Portability and Accounting Act and new HCFA requirements for systems architecture and security handbook. HCFA continues the development and enhancement of processes to limit overrides and to provide reasonable assurance that only authorized access to source code and programs is permitted. This will require the development and implementation of policies and procedures for safeguarding programs/systems that support claims processing and financial functions.

HCFA continued to make progress toward resolving this issue in FY 2000 by revising its information systems security requirements for Medicare contractors. *The HCFA Core Information Security Requirements* adheres to guidelines set forth in OMB circular A-130 and implement effective control procedures. Contractors are now required to document their compliance with *HCFA Core Information Security Requirements*.

## CONGRESSIONAL REPORTS

### **Medicare's Validation Program for Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 1999 Report**

#### ***Introduction***

Section 1865 of the Social Security Act (the Act) provides that JCAHO-accredited hospitals are deemed to meet the Medicare conditions of participation (CoPs). These hospitals are not subject to routine State surveys to assess compliance with the Medicare CoPs. Subsection 1864(c) of the Act, however, authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the JCAHO on a selective sample basis or in response to allegations of significant deficiencies that affect the health and safety of patients. The Act further requires, in Section 1875, that the Secretary include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the validation program.

The purpose of the validation program is to determine whether the JCAHO's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements at section 1861(e) of the Act for participation in the Medicare program as hospitals. Each year, the HCFA selects approximately 5 percent of the JCAHO-accredited hospitals to be surveyed. In 1998, the sampling methodology was improved from a six-month sampling process to a systematic year-round random sampling methodology. This change strengthened the validation of accredited hospitals by increasing the sample size from 79 hospitals in FY 1997 to 235 hospitals in FY 1999. A workgroup is developing selection criteria to further improve the hospital selection and evaluation methodology for validation of accreditation programs.

Sample validation surveys fall into three categories. They are:

1. Random sample (hospitals randomly selected for survey within 60 days after the JCAHO survey);
2. 18-month sample (hospitals randomly selected for survey at the midpoint of their 3-year JCAHO accreditation cycle); and
3. Conditional sample (hospitals randomly selected that had a JCAHO accreditation decision of conditional).

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO's standards. After completion of the on-site survey, the JCAHO makes an accreditation decision. The accreditation decisions include: accreditation, accreditation with Type I

## HCFA OTHER REPORTS

recommendations, conditional accreditation, and no accreditation.<sup>1</sup> Recently, the JCAHO discontinued the accreditation decision called accreditation with commendation. Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with Type I recommendations means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are corrected. The JCAHO requires hospitals with Type I recommendations to submit a written progress report or undergo a follow up survey. Conditional accreditation means that the hospital is in substantial noncompliance with JCAHO standards. Table 1 summarizes the JCAHO's accreditation decisions for Medicare-approved hospitals receiving a triennial survey in calendar years 1998 and 1999.

**Table 1**  
**JCAHO Accreditation Decisions,**  
**Medicare-Approved Hospitals Surveyed in 1998 and 1999**

Accreditation Decisions	No. Hospitals in 1998 (Percent)	No. Hospitals in 1999 (Percent)
Accreditation	253 (15.3)	187 (10.9)
Accreditation With Type I Recommendations	1381 (83.5)	1506 (87.6)
Conditional	20 (1.2)	26 (1.5)
Total Surveyed <sup>2</sup>	1655 (100)	1721 (100)

### **Validation Survey Findings**

Table 2 presents the number of random, 18-month, and conditional validation surveys HCFA performed, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was 'out of compliance'). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance. This table also includes a comparison of the compliance pattern between validation surveys of accredited hospitals and routine surveys of nonaccredited hospitals.

<sup>1</sup> JCAHO accreditation decisions also include preliminary nonaccreditation and provisional accreditation. [HCFA does not recognize provisional accreditation for deeming.] The JCAHO considers all hospitals to be 'accredited' except those that are not accredited. HCFA currently accepts the JCAHO definition of 'accredited' for deeming purposes.

<sup>2</sup> Categories do not sum to total because table does not include all accreditation categories.



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**Table 2**  
**Compliance Determinations of Validation and**  
**Nonaccredited Hospital Surveys, 1999**

Validation Type	No. Out of Compliance	Percent	Total
Random Validation	73	31	235
18-Month Validation	0	0	0
Conditional Validation	0	0	0
All Validations	73	31	235
Nonaccredited	9	4	232

Table 3 presents the percentage of JCAHO-accredited hospitals found out of compliance by category of validation survey for the years, 1996 through 1999.

**Table 3**  
**Percent of JCAHO Accredited Hospitals Out of Compliance**  
**by Category for Validation Survey Periods 1996 -1999**

Survey Type	1996	1997	1998	1999
Random	18	16	23	31
18-Month	31	100	NA <sup>3</sup>	NA <sup>3</sup>
Conditional	0	NA <sup>3</sup>	NA <sup>3</sup>	NA <sup>3</sup>

Deficiency data were analyzed for 20 of 21 Medicare hospital CoPs:<sup>4</sup>

### **Federal, State, and Local Laws**

Governing Body	Nursing
Medical Staff	Pharmaceutical
Infection Control	Laboratory
Quality Assurance	Medical Records
Discharge Planning	Physical Environment

### **Services**

Anesthesia	Respiratory Care
Rehabilitative	Emergency
Food & Dietetic	Outpatient
Surgical	Nuclear Medicine
Radiologic	

The three general health and safety CoPs found out of compliance most frequently for the 235 validation surveys performed in 1999 are shown in Table 4. The three CoPs found out of compliance most frequently for the 232 nonaccredited hospitals surveyed in 1999 are shown for comparison.

<sup>3</sup> Small or non-existent sample. Three JCAHO conditionally accredited hospitals were selected for validation surveys in 1998 and they were in compliance with the CoPs.

<sup>4</sup> The CoP not analyzed was Utilization Review. Accredited hospitals do not receive deemed status for this CoP.

## HCFA OTHER REPORTS

**Table 4**  
**Most Frequently Cited Conditions of Participation**  
**During Surveys, 1999**

<u>Accredited Hospitals</u>	<u>Frequency</u>	<u>Nonaccredited Hospitals</u>	<u>Frequency</u>
1 Physical Environment Life Safety Code	60	1 Quality Assurance	19
2 Food and Dietetic Services	3	2 Medical Staff	8
Medical Staff	3	Pharmaceutical Services	8
Discharge Planning	3		
3 Infection Control	2	3 Governing Body	7
Governing Body	2		
Medical Records	2		
Anesthesia Services	2		

### ***JCAHO Survey Process for Life Safety Code (LSC)***

Since 1995, the JCAHO has been evaluating hospital compliance with LSC by having the hospital assess its own compliance and record the findings and plans for correction on the JCAHO Statement of Conditions (SoC) document. If a JCAHO surveyor identifies a LSC deficiency that has not been self-reported on the SoC by the hospital, it is 'scored' (i.e., it becomes a recommendation on the accreditation report). A self-assessed deficiency is not scored and reported on the accreditation report unless the surveyor determines that the hospital is making little or no progress in correcting that deficiency. HCFA surveys do not include a self-assessment by the hospital. Any deficiencies noted by State surveyors are included on the Federal Form HCFA-2567, Statement of Deficiencies and Plan of Correction. Although taken into account in this report, at the present time comparison of specific LSC deficiencies found using the JCAHO self-assessment and the HCFA survey process is difficult. Another difficulty in comparing the two survey standards and processes is the differences in the two editions of the LSC used by HCFA (1985 edition) and the JCAHO (1997 edition) and the reporting forms used by each. Revisions to language in the later edition of the LSC (1997) do not allow for the development of an easily used crosswalk between the two survey processes at this time.

### ***Allegation Surveys***

In addition to the validation surveys, HCFA conducts substantial allegation (complaint) surveys of JCAHO-accredited hospitals in response to incoming complaints involving potential threats to the health and safety of patients. Then HCFA evaluates each complaint. If HCFA believes that the hospital would have a CoP out of compliance, the Agency authorizes the State to conduct a substantial allegation survey.

In 1999, 1628 allegation surveys of JCAHO-accredited hospitals were conducted with 115 found out of compliance with one or more CoPs. Also, 259 allegation surveys of

## HCFA OTHER REPORTS

non-accredited hospitals were conducted with 23 found out of compliance with one or more CoPs. Table 5 summarizes the most frequently cited CoPs.

**Table 5**  
**Most Frequently Cited Conditions of Participation,**  
**During Allegation Surveys, 1999**

<u>Accredited Hospitals</u>		<u>Nonaccredited Hospitals</u>	
Condition Not Met	Frequency	Condition Not Met	Frequency
Nursing Services	27	Quality Assurance	4
		Emergency Services	4
		Infection Control	4
Quality Assurance	21	Nursing Services	3
		Governing Body	3
		Physical Environment	3
Governing Body	20	Pharmaceutical Services	2

### ***Rate of Disparity***

As set forth in regulation at 42 Code of Federal Regulations 488.8(d)(2)(l), following the end of a validation review period, HCFA will identify any accreditation program for which validation survey results indicate a 20 percent or more rate of disparity between the findings of the accreditation organization and the State agency. Accreditation programs with a disparity rate of 20 percent or more will be subject to a deeming authority review to determine if that organization has indeed adopted and maintained requirements comparable to HCFA's. Of the 235 JCAHO validation surveys performed in 1999, 73 showed condition-level noncompliance. Comparing the survey reports of these hospitals with the corresponding JCAHO accreditation reports, 32 of the 76 validation surveys showed comparable condition-level deficiencies.

Of the 32 validation surveys that showed comparable condition-level deficiencies, 30 were physical environment/life safety code condition-level deficiencies. Each hospital identified by a State survey agency during the validation survey with a physical environment/life safety code condition-level deficiency has a Plan for Improvement approved by the JCAHO. Therefore, these 30 physical environment condition-level deficiencies are not counted against the JCAHO in calculating the disparity rate. The disparity rate for 1999 is based on the 41 conditional-level deficiencies identified by the State survey agencies where comparable condition-level deficiencies do not exist in the JCAHO accreditation survey reports. This equals a disparity rate of 17.4 percent (which is below HCFA's cutoff point of 20 percent).



### ***Changing the Evaluation Methodology and Future Plans for Validation***

The OIG released four reports entitled, "The External Review of Hospital Quality" in July of 1999. The reports were based on the OIG's broad inquiry of the external quality oversight of hospitals. The reports identified recommendations that HCFA is considering in order to improve its oversight role of accreditation organizations for hospitals. HCFA has established several workgroups to develop its Hospital Quality Oversight Initiative, which is designed to address the recommendations made by the OIG. HCFA has identified four goals to address the OIG recommendations. The goals to address the OIG's recommendations are 1) Balance quality improvement and regulatory approach; 2) Improve oversight of JCAHO's activities; 3) Improve oversight of State agency activities; and, 4) Improve oversight of nonaccredited hospitals.

Under this initiative, HCFA has revised its hospital validation program to improve oversight of hospital accreditation programs. After reviewing the weaknesses of the current hospital validation program and analyzing other validation reviews, a HCFA workgroup developed two new validation survey types that are designed to improve HCFA's oversight of hospital accreditation programs. The two survey types identified are 1) Concurrent/Observational Validation Survey, and 2) Mid-Cycle (focused) survey. HCFA will continue to conduct some validation surveys using the traditional 60-day look back methodology. The Concurrent/Observational Survey is an announced survey with a regional office surveyor(s) observing the conduct of the JCAHO survey while the State survey agency concurrently conducts a full comparative survey.

The goal of the Concurrent/Observational survey process is to provide HCFA with quantitative and qualitative data about the effectiveness/ability of the deeming organization's survey process to provide reasonable assurance that the hospital meets or exceeds the Medicare requirements for hospitals. HCFA will initiate the pilot Concurrent/Observational survey beginning January 2001 in the States of Michigan, Illinois and California.

HCFA will also procure an independent contractor to evaluate the effectiveness of the revised hospital validation program, funds permitting.

# VALIDATION SURVEYS OF ACCREDITED LABORATORIES UNDER THE CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 (CLIA) – 1999 REPORT

## Introduction

This report covers the evaluation of fiscal year 1999 by the six accreditation organizations approved under CLIA. The six organizations are:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA (Commission on Office Laboratory Accreditation)
- College of American Pathologists (the College)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by statute, we see this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

## ***Legislative Authority and Mandate***

Section 353 of the Public Health Service Act, as amended by CLIA, requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct Federal oversight by HCFA. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is “deemed” to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and other accurate and reliable laboratory examinations and procedures.

In Section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and “such other means as the Secretary determines appropriate.” In addition, the Secretary is required to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing Section 353 are contained in 42CFR Part 493 Laboratory Requirements. Subpart E of Part 493 contains the requirements for validation inspections, which are conducted by HCFA or its agent, to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization’s inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or “surveys” provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization’s standards and accreditation process; and
- in the aggregate, an indication of the organization’s capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in Section 493.575 of Subpart E, provides that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization’s results and the findings of the CLIA validation surveys, HCFA can re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called “deeming authority”). Section 493.575 further provides that HCFA has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization’s accreditation process that the requirements are no longer equivalent to CLIA requirements.

### ***Validation Reviews***

The validation review methodology focuses on the actual implementation of the organization’s accreditation program described in its request for approval. The accreditation organization’s standards, as a whole, were approved by HCFA as being equivalent to, or more stringent than, the CLIA condition-level requirements\*. This equivalency is the basis for granting deeming authority.

In evaluating the organization’s performance, it is important to examine whether the organization’s inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization’s inspection process sufficiently identifies, implements and monitors corrections of laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

\* A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed and more specific. A condition-level deficiency is an inadequacy in the laboratory’s quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.



For each laboratory in the sample, any findings from the CLIA validation survey that result in deficiencies at the condition-level are compared to the accreditation organization's inspection results to determine comparability. If it is reasonable to conclude that one or more of those deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all the cases in the sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by Section 493.2 of the CLIA regulations.

### ***Number of Validation Surveys Performed***

As directed by the CLIA statute, the number of validation surveys is sufficient to "allow a reasonable estimate of the performance" of each accreditation organization.

A representative sample of the more than 14,000 accredited laboratories received a validation survey in 1999. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by any one organization fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, was subject to only one validation survey – for the organization it selected to maintain its CLIA certification – irrespective of the number of accreditations it has.

Fewer than a total of 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College or the Joint Commission, thus the sample sizes for these organizations were larger. The sample sizes are usually proportionate to each organization's representation in the universe of accredited laboratories, however, true proportionality is not always possible due to scheduling difficulties, as experienced in 1999.

The effect of sample size on the disparity rate computation should also be noted. When a sample size is larger, as used for the larger organizations, the disparity rate rises in increments of a few percent for each additional disparate case. One disparate case, for example, could result in a disparity rate of three percent. On the other hand, when a sample size is smaller, the disparity rate rises in much larger increments. One disparate case in a small sample could result in a disparity rate of 17 percent.

The number of validation surveys performed for each organization is specified in the following section.

### ***Results of the Validation Reviews of Each Accreditation Organization***

The findings for each organization are summarized below:

#### **American Association of Blood Banks**

Rate of disparity: 14 percent

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Approximately 250 laboratories used their AABB accreditation for CLIA purposes. Seven validation surveys were conducted. No condition-level deficiencies were cited on any of the cases, except one. This one disparate case, however, resulted in a disparity rate of 14 percent due to the small number of surveys.

Following is the identification number and location of the laboratory that had a disparate inspection result by the AABB, along with the CLIA condition-level requirement cited on the validation survey.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
16D0383665	Iowa	Proficiency Testing-Enrollment

### **American Osteopathic Association**

Rate of disparity: No disparity

For CLIA purposes, approximately 50 laboratories used their AOA accreditation. Three validation surveys were conducted. All three laboratories were found to be in condition-level compliance, so there was no question of disparate findings.

### **American Society of Histocompatibility and Immunogenetics**

Rate of disparity: No disparity

About 150 laboratories used their ASHI accreditation for CLIA purposes. Two validation surveys were considered reasonable to evaluate this organization's performance. Condition-level compliance was found in both validation surveys, thus there could be no disparity.

### **COLA**

Rate of disparity: 2 percent

Validation surveys were conducted at 122 COLA-accredited laboratories. Fifteen laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by COLA in all but two of these laboratories.

Following is a listing of the laboratory identification number and location of laboratories that had disparate inspection results by COLA, along with the CLIA condition-level requirements cited on the validation surveys.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
31D0121723	New Jersey	Proficiency Testing - Successful Participation
40D0699278	Puerto Rico	Proficiency Testing - Successful Participation

### **College of American Pathologists**

Rate of disparity: 9 percent

A total of 35 validation surveys were conducted at laboratories accredited by the College. Three of the laboratories were cited with condition-level deficiencies. Comparable deficiencies were not cited by the College in all three cases.

## HCFA OTHER REPORTS

Following is a listing of the CLIA identification number and the location of the laboratories that had disparate inspection results by the College, along with the condition-level requirements cited on the validation surveys.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
16D0385722	Iowa	Proficiency Testing – Enrollment
17D0451411	Kansas	Proficiency Testing – Successful Participation
31D0004614	New Jersey	Quality Control – General Laboratory Director

### **Joint Commission on Accreditation of Healthcare Organizations**

Rate of disparity: 3 percent

During this validation period, 58 validation surveys were conducted at laboratories accredited by the Joint Commission. Only two of the laboratories were cited with condition-level deficiencies, however, comparable deficiencies were not cited by the Joint Commission for either laboratory.

Following is a listing of the CLIA identification number and location of the laboratories that had disparate inspection results by the Joint Commission, along with the CLIA condition-level requirements cited on the validation surveys.

<u>CLIA number</u>	<u>Location</u>	<u>CLIA Conditions</u>
12D0619435	Hawaii	Quality Control
15D0362073	Indiana	Quality Assurance – Laboratory Director

### **Conclusion**

HCFA has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. The findings of the validation review for 1999 indicate that all of the accreditation organizations performed at a level well below the 20 percent threshold that would trigger a deeming authority review. Moreover, the validation review did not reveal widespread or systematic problems in accreditation processes that cause the equivalency of any organization's accreditation program to be questioned.

In addition to assessing each organization's program equivalency through validation surveys, HCFA has been active in promoting opportunities for partnering with the organizations in furthering our mutual interest in improving laboratory practices and outcomes across the nation. In 1999, a workgroup of HCFA and State agency surveyors was convened to develop a protocol for conducting a CLIA validation survey at the same time as the accreditation organization conducts its inspections. This "simultaneous validation survey" protocol was designed to supplement the "look behind" protocol traditionally employed in CLIA validation surveys. The supplemental protocol was slated for implementation on a trial basis in fiscal year 2000, with modifications as appropriate based on feedback from the organizations, surveyors, and laboratories. Highlights of that operational experience will be discussed in the fiscal year 2000 report.



## **REPORT ON PEER REVIEW ORGANIZATIONS (PRO)**

Over the last several years, HCFA has re-engineered the PRO program to better meet the Agency's strategic goal of improving the health status of Medicare beneficiaries. PROs still perform quality assurance activities in accordance with their original mandate. However, the principal focus of the PRO program has evolved from a mix of utilization review, diagnosis related group (DRG) validation and quality of care review to an expanded approach that features emphasis on quality improvement projects through the Health Care Quality Improvement Program (HCQIP). For the sixth round of PRO contracts, now entering the second year of a 3-year cycle, a substantial level of effort is also being directed at Medicare program integrity via the Payment Error Prevention Program (PEPP) in compliance with the Balanced Budget Act.

The HCQIP relies on provider-based quality improvement, a data driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. PROs conduct a wide variety of improvement projects on important clinical and non-clinical topics that have the potential to improve care provided to many Medicare beneficiaries. Such projects vary in size depending on the study purpose and design. For example, there are "national" projects featuring six clinical topic areas (viz., acute myocardial infarction, heart failure, diabetes, breast cancer, pneumonia, and stroke) that HCFA has determined to have a high impact on Medicare beneficiaries; where the process measures are linked to outcomes; where room for improvement exists; and where PROs have experience with the topic. Similarly, individual PROs also design and structure "local" projects whereby they work collaboratively with specific providers and managed care plans in their areas, particularly with respect to disadvantaged and/or under-served beneficiary groups. PROs are also conducting pilot projects in alternative provider settings.

Consistent with the Agency's strategic goal to promote the fiscal integrity of HCFA programs, the newly implemented PEPP activities are part of the Comprehensive Plan for Program Integrity to ensure Medicare hospital inpatient claims are billed and paid appropriately. Using HCFA-developed baseline data, each PRO is now required to identify the extent of payment errors occurring in its area; implement appropriate educational interventions aimed at changing provider behavior; and decrease the observed payment error rate. The overall target for the 3-year contract period is a 50 percent reduction nationally in payment errors for claims by acute care hospitals under Medicare's Prospective Payment System.

Under Federal budget rules, the PRO program is defined as "mandatory" rather than "discretionary" because PRO costs are financed directly from the Medicare Trust Funds and are not subject to the annual appropriations process. PRO outlays in FY 2000 totaled \$278.7 million, which compares with \$213.4 million spent in FY 1999.

In FY 2000, HCFA administered 53 PRO performance-based contracts, one per State, the District of Columbia, the Virgin Islands, and Puerto Rico. Program compliance is ensured via performance-based evaluation measures for both project results and program integrity efforts, as well as use of inter-rater reliability measures and International Organization for Standardization (ISO) 9000-type documentation of PRO processes.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION**

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# **Glossary**





## GLOSSARY

**Accrual Accounting:** An accounting technique that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual income.

**Actuarial Soundness:** A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

**Administrative Costs:** General term that refers to Medicare and Medicaid administrative costs, as well as HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA (e.g. salaries and expenses, facilities, equipment, rent and utilities, etc). These costs are reflected in the Program Management account.

**Balanced Budget Act of 1997 (BBA):** Major provisions include the State Children's Health Insurance Program, Medicare+Choice, and expansion of preventive benefits.

**Beneficiary:** A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

**Benefit Payments:** Funds outlayed or expenses accrued for services delivered to beneficiaries.

**Carrier:** A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

**Cash Accounting:** An accounting technique that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

**Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP):** A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

**Demonstrations:** Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such

## GLOSSARY

projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

**Discretionary Spending:** Outlays of funds subject to the Federal appropriations process.

**Disproportionate Share Hospital (DSH):** A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

**Durable Medical Equipment (DME):** Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

**Durable Medical Equipment Regional Carrier (DMERC):** A company that contracts to pay Medicare claims for purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

**Expenditure:** Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

**Expense:** An outlay or an accrued liability for services incurred in the current period. This term is used to show accrual accounting.

**Federal General Revenues:** Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

**Federal Insurance Contribution Act (FICA) Payroll Tax:** Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1999, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

**Federal Medical Assistance Percentage (FMAP):** The portion of the Medicaid program which is paid by the Federal government.

**Federal Managers' Financial Integrity Act (FMFIA):** A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

**Health Care Prepayment Plan (HCPP):** A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

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**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

**Hospital Insurance (HI):** The part of Medicare that pays hospital and other institutional provider benefit claims. See “Part A.”

**Information Technology (IT):** The term commonly applied to maintenance of data through computer systems.

**Intermediary:** A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

**Internal Controls:** Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as Management controls.

**Mandatory Spending:** Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

**Material Weakness:** A serious flaw in management or internal controls requiring high priority corrective action.

**Medicare Current Beneficiary Survey (MCBS):** A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

**Medicare Contractor:** A collective term for carriers and intermediaries.

**Medicare+Choice:** A provision in the BBA that restructures HCFA's authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed to participate in Medicare, as well as preferred provider organizations (PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

**Medicare Integrity Program (MIP):** A provision in HIPAA that sets up a revolving fund to support HCFA's program integrity program.

**Medicare Trust Funds:** Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.



## GLOSSARY

**Medical Review/Utilization Review (MR/UR):** Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

**Medicare Secondary Payer (MSP):** A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

**Obligation:** Budgeted funds committed to be spent.

**Outlay:** Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits. Used for cash accounting.

**Part A:** The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or “HI.”

**Part B:** The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or “SMI.”

**Payment Safeguards:** Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

**Peer Review Organization (PRO):** PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

**Program Management:** HCFA’s operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

**Provider:** A health care professional or organization providing medical services.

**Recipient:** An individual covered by the Medicaid program, however, now referred to as a beneficiary.

**Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP):** A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member’s medical care costs are paid for in return for a monthly premium. However, due to the “lock-in” provision, all of the enrollee/member’s services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO’s health care system/network.

## GLOSSARY

**Revenue:** The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

**Self Employment Contribution Act (SECA) Payroll Tax:** Medicare's share of SECA is used to fund the HI Trust Fund. In FY 1999, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

**State Certification:** Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

**State Children's Health Insurance Program (SCHIP) (also known as Title XXI):** This is a provision of the BBA that provides federal funding through HCFA to States so that they can expand child health assistance to uninsured, low-income children.

**Supplementary Medical Insurance (SMI):** The part of Medicare that pays physician and supplier claims. See "Part B."

**Tax and Donations:** State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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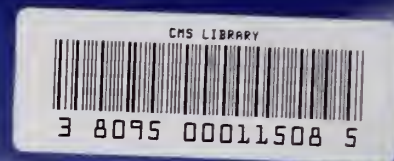
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**T**he Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this *Financial Report* follows guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Health Care Financing Administration's (HCFA) support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

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